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SAN FRANCISCO MENTAL HEALTH BOARD

Gavin Newsom
Mayor

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.sfgov.org/mental_health

MEETING OF THE MENTAL HEALTH BOARD

Wednesday, January 10, 2007

City Hall

One Carlton B. Goodlett Place

2nd Floor, Room 278

6:30 p.m.

DOCUMENTS DEPT.

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CALL TO ORDER

ROLL CALL

AGENDA CHANGES

Item 1.0 DIRECTORS REPORT

For discussion.

1.1 Discussion regarding Community Behavioral Health Services Department Report, a report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.

1.2 Public comment relevant to Item 2.0

Item 2.0 PRESENTATION: Disproportionality Task Force, Robin L. Love, MCP, Family Preservation and Support Program Coordinator, Human Services Agency

For discussion.

2.1 Presentation:

2.2 Board discussion of possible Board responses to the presentation.

2.3 Board discussion of future presentations and agenda items.

2.4 Public comment relevant to Item 3.0

Item 3.0 ACTION ITEMS

For discussion and action.

3.1 Public comment relevant to Item 3.0

3.2 Proposed Resolutions

3.2.a PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of November 8, 2006 be approved as submitted.

3.2.b PROPOSED RESOLUTION: Be it resolved that the notes of the Mental Health Board Retreat of December 9, 2005 be approved as submitted.

3.2.c PROPOSED RESOLUTION: Responding to Critical Foster Care Issues and Concerns. (Attachment A)

3.2.d PROPOSED RESOLUTION: Be it resolved that the Mental Health Board commends Carmen Lee and Stamp Out Stigma. (Attachment B)

3.2.e PROPOSED RESOLUTION: Be it resolved that the Mental Health Board commends Behavioral Health Court. (Attachment C)

3.2.f PROPOSED RESOLUTION: Be it resolved that the Bylaws of the Mental Health Board be changed as attached. (Attachment D)

Item 4.0 MENTAL HEALTH BOARD PRIORITIES FOR 2007

4.1 Public Comment relevant to Item 4.0

4.2 PROPOSED RESOLUTION

RESOLUTION (MHB-2007-xx) Be it resolved that the following priorities be adopted by the Board for 2007 (Attachment E):

1. Develop new partnerships with other organizations in order to collaborate on mental health issues.
2. Lead and participate in education and advocacy efforts in identified legislative areas.
3. Provide education to San Francisco organizations and the community about critical mental health issues.

Item 5.0 REPORTS

For discussion and possible action.

5.1 Report from the Executive Director of the Mental Health Board.

5.2 Report of the Chair of the Board and the Executive Committee.

5.3 Program's Committee Report: Rebecca Turner, Ph.D.

5.3a Planning Committee Task Force Report: Tom Purvis

5.4 Budget Committee Report: James McGhee

5.5 Report by members of the Board on their activities on behalf of the Board.

5.6 New business - Suggestions for future agenda items to be referred to the Executive Committee.

5.7 Public comment relevant to Item 5.0

Item 6.0 PUBLIC COMMENT

Members of the public may address the Mental Health Board on any items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board.

ADJOURNMENT

DISABILITY ACCESS

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Frank Darby
Sunshine Ordinance Task Force
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689
Telephone: (415)554-7724
Fax: 4(15) 554-5163
E-mail: sotf@sfgov.org

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**MENTAL HEALTH BOARD
ATTACHMENT A
January 10, 2007**

PROPOSED RESOLUTION (MHB-2007-xx): RESPONDING TO CRITICAL FOSTER CARE ISSUES AND CONCERNS

WHEREAS, 2,200 San Francisco children are in foster care, and

WHEREAS, 70% of the children in foster care are African American, while only 8% of the City's population is African American, and

WHEREAS, too many children in foster care end up in the criminal justice system, and

WHEREAS, 24% of the San Francisco murder victims were previously in foster care, and

WHEREAS, 39% of the suspects committing the murders in San Francisco were in foster care, and

WHEREAS, the substance abuse rate is higher for foster care kids, and

WHEREAS, the suicide rate is significantly higher for foster care kids, and

WHEREAS, many Grandparents are assuming responsibility for caring for their grandchildren, and

WHEREAS, the potential for child abuse is higher in foster care, and

WHEREAS, 55% of foster care children receive mental health services, and

WHEREAS, children are being released out of the foster care system without needed support, knowledge, and vocational skills to succeed, and

WHEREAS, mental health care for children in foster care when they are young will save tax dollars in the future.

BE IT RESOLVED that financial support and mental health services for grandparents taking care of grandchildren needs to be available, and

BE IT FURTHER RESOLVED that transitional care for youth 18 and older who age out of the system such as: job training, housing, school vouchers, financial aid, transportation (muni passes), and family planning needs to be available, and

BE IT FURTHER RESOLVED that the trend of case load reduction for child welfare workers be continued so that appropriate oversight is possible, and

BE IT FURTHER RESOLVED that all children entering the Foster Care System need a mental health assessment and counseling made available.

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**MENTAL HEALTH BOARD
ATTACHMENT B
January 10, 2007**

**PROPOSED RESOLUTION (MHB-2007-X): COMMENDING STAMP OUT STIGMA
AND CARMEN LEE.**

WHEREAS, Stamp Out Stigma, founded by Carmen Lee, is a nonprofit organization that is dedicated to raising awareness of mental illness among the public, and

WHEREAS, Stamp Out Stigma, using panelists who suffer from mental illness, educates people about the experience of being mentally ill, and

WHEREAS, Stamp Out Stigma contributes to reducing the stigma associated with mental illness by showing the human side of mental illness, and

WHEREAS, Stamp Out Stigma has given nearly 1,000 presentations to diverse audiences over the past ten years, and

WHEREAS, Carmen Lee, its founder has won many awards including a Lifetime Achievement Award from the Voice Awards, and

WHEREAS, Stamp Out Stigma contributes to educating the public in the hope that it will lead to greater compassion and understanding by all.

THEREFORE, BE IT RESOLVED, that the Mental Health Board of San Francisco commends and thanks the Carmen Lee and Stamp Out Stigma for their years of dedication and commitment to educating the public about mental illness.

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MENTAL HEALTH BOARD ATTACHMENT C January 10, 2007

PROPOSED RESOLUTION (MHB-2007-xx): IN SUPPORT OF THE BEHAVIORAL HEALTH COURT

WHEREAS, far too many people with mental illness end up in the criminal justice system rather than in the mental health system, and

WHEREAS, these people with mental illness need treatment rather than punishment, and

WHEREAS, the Behavioral Health Court is proving itself to be a very effective and humane way to help mentally ill offenders get into treatment, and

WHEREAS, the Behavioral Health Court involves a multidisciplinary team and is an excellent role model for the coordination and integration of services across City departments, and

WHEREAS, the Behavioral Health Court helps keep clients from falling into the cycle of recidivism, and

BE IT RESOLVED, that the San Francisco Mental Health Board commends the City and County of San Francisco for creating and supporting the Behavioral Health Court, and

BE IT FURTHER RESOLVED, that the Mental Health Board commends the Superior Court of the City and County of San Francisco, and especially Judge Mary Morgan and her colleagues for their strong commitment to the Court and their compassion for the clients of the Court, and

BE IT FURTHER RESOLVED, that the Mental Health Board urges the City and County of San Francisco to make it a priority to increase funding and support for the Court, so the Court can increase the number of clients it works with.

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MENTAL HEALTH BOARD

ATTACHMENT D

January 10, 2007

PROPOSED RESOLUTION (MHB-2007-xx): Be it resolved that the Mental Health Board amends its bylaws as recommended by the Executive Committee in order to revise its attendance policy.

ARTICLE III - MEMBERSHIP

The membership of the MHB shall at all times be as provided for in California Welfare and Institutions Code Sections 5604 et. seq., and San Francisco Administrative Code Sections 15.3 et. seq. This legislation includes a provision that a member shall be removed from office if he or she is absent from four meetings in one year. A leave of absence may be granted for up to ~~two~~ *three* months with prior approval of the Executive Committee. *In the case of medical illness, family emergency or other exigency, the Executive Committee may retroactively grant leaves as necessary.* If it is determined that a member has been absent from four meetings within a 12 month period, and no leave of absence has been granted, the MHB shall notify the Board of Supervisors in writing. Upon receipt of this notification, the position shall be declared vacant by the Board of Supervisors.

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MENTAL HEALTH BOARD ATTACHMENT E January 10, 2007

RESOLUTION (MHB-2007-xx) Be it resolved that the following priorities be adopted by the Board for 2007:

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3. Provide education to San Francisco organizations and the community about critical mental health issues.

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MEETING NOTES

Mental Health Board

Wednesday, January 10, 2007

City Hall, Room 278

San Francisco, CA 94102

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BOARD MEMBERS PRESENT: James L. McGhee (Vice-Chair); Bridgett Brown; Benito Casados; Jeanna Eichenbaum, L.C.S.W.; Toye Moses, Ph.D., M.P.H.; Lisa Williams; Kate Walker; Virginia Wright.

BOARD MEMBERS ABSENT: Rebecca Turner, Ph.D. (Chair); James Shaye Keys (Secretary); Bob Douglas, Esq; John Kevin Hines; Claudia Lebish; Tom Purvis; Jagruti Shukla, M.D., M.P.H.

OTHERS PRESENT: Helynna Brooke (MHB Executive Director); Ayana Baltrip-Balagas (MHB Administrator); Michele Maas, Native American Health Center (Member of the Public); Emeric Kalman, (Member of the Public); Laura Barber, (Member of the Public); Ruth Jackson, Polly's Family Support (Member of the Public); LaVaughn King, Member of the Public.

CALL TO ORDER

The meeting was called to order at 6:35 p.m. by James L. McGhee (Vice-Chair).

ROLL CALL

Ms. Brooke read the roll.

1.0 DIRECTOR'S REPORT

Dr. Cabaj: "Happy New Year. We had good news. Indigent Care has been restored. It took a long time for the money to be found to restore care for indigent patients in our Private Provider Network (PPN). We have a network of over 400 clinicians in the City who see our clients, both MediCal and indigent who don't need full services but can still benefit from seeing a therapist. We were able to restore indigent clients to the PPN. Prior to this, patients had to go to clinics for care.

This is good news but we are running out of providers. We are looking at this issue over the next year making sure we have adequate referrals.

The Mental Health Association, a great ally and support to the City is now 60 years old. It's been one of the longest running organizations in California, and we are very glad that we work closely together. They were one of the major advocates in getting the Mental Health Services Act pulled together, not just fast, but with our county being the highest percentage of voters supporting it.

We are having our public forum meeting concerning the Mental Health Services Act on Wednesday, January 31, 2007. (See Item 5 in 'Monthly Director's Report below for location and time.) Benito Casados is our community co-chair of this meeting.

We will look at some of the new funding added to next year's cycle as well as an update of where we are with information from the State. We were given a little over \$2 million more for clinical services, and they will mostly be used for extending the services we have; but we may have a window of opportunity to add one or two things that didn't get funded in the first cycle. That will be part of our discussion.

We are still waiting for close to \$13 million that is for all the other allocated money: the education prevention, the outreach and engagement dollars, the Capital IT. No information from the State yet. We believe we will learn more about the education dollars in April, and maybe by the summer about the prevention funding.

Those are the two sets of dollars we would like to get out because they would make a difference to people right a way. IT and other things will be part of an infrastructure, but we would love to be able to start doing prevention programs, innovative programs, and trainings. Training includes peer employment development and expansion; so that is why these are very key funds.

You see how long it takes for dollars to get from the State to us, and then to the real world. It's over two years that the law (Proposition 63) passed. It's over one year that the plan got accepted. We had to go through Requests for Proposals (RFPs). Last month and by the beginning of this month, the first clients were being seen with these dollars. We are finally making some progress. This is actually a pretty fast time frame compared to what some other counties go through. I'm very pleased that we are finally getting into true action. In the next month, I expect the process to continue to expand.

Part of this expansion is hiring peers. I think Mr. Casados has been helping with the interview process. They are called 9924 positions, a code name for the Human Resources position; and they will be helping with the administrative structure of CBHS. We'll be able to expand the role of peers and family members. This is a great stepping-stone for future peer employment development and expansion. Both Hyde Street Community Services and Central City Hospitality House will be looking at expanded peer employment options and different positions. (See full report below.)

We will have more peer and staff trainings throughout the year—Motivational Interviewing, Ethics and Law, Hoarding and Cluttering, and Dialectical Behavioral Therapies (DBT). Our director, Dr. Katz is seeing if funding can be expanded to support DBT trainings.

One caveat, Governor Schwarzenegger seems to think he can use Mental Health Services Act dollars for some of his programs. There's talk that he wants to cut AB2034, one of our best homeless outreach programs for the mentally ill. Our immediate response is that you can't do that, because the Mental Health Services Act says you cannot use these dollars to backfill another service. I'll be in Sacramento again tomorrow and I'll find out if there has been a response to this. He also wants to use money from Proposition 36, the Substance Abuse Treatment instead of Incarceration Bill. I just have the earliest hint of this. I will find out more detail. Watch the news, you'll probably hear more about this."

Mr. Casados: "The news said tonight that the Governor wants to cut up to one-third of the funding from these two bills."

Dr. Cabaj: "This is the biggest fear, you get a new source of money, and there is going to be some attempt to grab it for other things. I suspect there is going to be a huge outcry on this one.

This is his first foray into the budget. The real budget to worry about is the one in May. Hopefully we can make some intervention between now and then."

Dr. Moses: "So what can we do at the local level."

Dr. Cabaj: "The Mayor just came to us for an analysis. If you want to take a position on this, do not support any reduction in state funding for current programs even if it's backfilled from something else, because all that means is we can't grow. We would just have to maintain.

It's probably too early now, but by next month we might ask you for special support on this.

One thing that wasn't mentioned in the last meeting is that we as a county did win money from the State for the Mentally Ill Offender Grant. The money returned. We won the money for the adult services but not for the youth. This money will allow us to create some positions to help the Behavioral Health Court."

Monthly Director's Report
December 13, 2006 & January 10, 2007

1. **Support Group for Families of the Mentally Ill.** A support group for family members and friends of the mentally ill, professionally facilitated by Susanne Killing, MS, CNS,

ANP and Jane Goldman, MS, CNS, is taking place weekly every Tuesday, 5:15 to 6:45 PM, at San Francisco General Hospital, 7th Floor, Room 7M30. You may simply drop-in to attend the support group, or contact Susanne Killing at (415) 558-5900 for more information. This regular family support meeting is sponsored by the National Alliance for the Mentally Ill, and provides weekly peer support; education about mental illness; and information regarding community resources.

2. **Support Group for Schizophrenia or Schizoaffective Disorder.** A support group for people with Schizophrenia or Schizoaffective Disorder, co-facilitated by a mental health professional and a peer, is taking place every third Wednesday of the month, 5:30 to 6:45 PM, at 1380 Howard St. , Room 537 (5th floor). You may simply drop-in to attend the support group, or call one of the facilitators, Susanne Killing at (415) 558-5900, for more information. The group meeting dates for 2007 are January 17, February 21, March 21, April 18, May 16, June 20, July 18, August 15, September 19, October 17, November 21, and December 19. Dinner is provided.
3. **PPN Opens to Indigents.** Additional funding has been identified for FY 06-07 for the CBHS Private Provider Network, and therefore slots are now available in the PPN for mental health treatment for uninsured individuals. These opened slots will relieve some of the strain placed on CBHS outpatient mental health clinics. Effective November 13, 2006, all *new* uninsured clients calling the CBHS Central Access Team, or being referred to the Central Access Team, to request mental health services will be screened for medical necessity, and referred to the PPN as appropriate. *Existing indigent clients* currently being treated by CBHS mental health outpatient programs will continue their treatment at their respective programs. The number of openings for referrals of indigents to the PPN is limited by the amount of funding identified for the PPN for 06-07, and will be monitored monthly to track the level of available funding.
4. **SF Mental Health Association Turning 60.** A special milestone is fast approaching for the Mental Health Association of San Francisco (MHA-SF). In just a few months, MHA-SF will celebrate its 60th year of providing education, advocacy, research, and service for San Francisco community! Over the last six decades, MHA-SF has touched the lives of hundreds of thousands of individuals challenged by mental illness. MHA-SF's programs have the dual focus of education and training, as well as public policy and advocacy.
5. **Mental Health Services Act (MHSA) Update.**
The MHSA Advisory Committee will be meeting on Wednesday, January 31, 2007 from 3-5pm in the Tenderloin community at the San Francisco Community Club House, 134 Golden Gate Avenue, San Francisco.

COMMUNITY SERVICES AND SUPPORTS GROWTH FUNDS

The California Department of Mental Health has revised the county allocations for Fiscal Year 2007 – 2008 for the Community Services and Supports component of MHSA using two factors: the need for mental health services and population most likely to access mental health services; adjustments for cost of being self sufficient and available resources; and an increase in base level funding. This revision is due to an excess in actual revenues received compared to what had originally been budgeted. San Francisco's new allocation is \$7,995,700, which is \$2,292,795 more than the original allocation.

No further updates have been received from the State regarding the distribution of the Prevention and Education, Outreach and Engagement, and Capital and IT Infrastructure components of MHSA.

MHSA – FSP SERVICES ROLL-OUT for CBHS:

The Adult System of Care has authorized 2 partners with citywide Case Management, 1 with Family Service Agencies, and 5 with Hyde Street Community Services to receive full service partnership services. Seneca has enrolled 18 children as full service partners.

PEER HIRING

CBHS 9924 Positions:

Letters will be sent out to the 20 applicants asking them to detail their experiences as mental health consumers or family members of mental health consumers. Interviews will be scheduled in the first weeks of January.

The following agencies have forwarded their job flyers to CBHS for distribution. These flyers have been inserted in the binders available on the fifth floor:

Hyde Street Community Services – is seeking a mental health consumer to work as a peer counselor for their FSP program.

Central City Hospitality House – is seeking the following positions:

- Shelter Program Case Manager (Bi-lingual English/Spanish)
- Shelter Program and Self-Help Center Peer Service Advocate and Substitute Peer Service Advocates (Bi-lingual Spanish/English)
- Community Arts Program Studio Assistant and Substitute Studio Assistants (Bi-lingual in English and either Spanish, Russian, Vietnamese or Chinese)

PEER AND STAFF TRAINING SCHEDULES

In the New Year, the following trainings are tentatively scheduled pending logistical and final arrangements with guest speakers:

- Employment/Cultural Competency with Consumers (2 day training)
- Motivational Interviewing for Clinicians
- Law & Ethics for Mental Health & Substance Abuse
- Hoarding and Cluttering
- DBT Training

6. **CBHS Integration.** After a summer hiatus, the Integration Advisory Committee (IAC) reconvened in December to review policy issues and advise CBHS on integration activities. There is a broad representation of services in this group, but additional providers are welcome to attend. Please contact Kathleen Minioza at 255-2585 if you are interested in joining the IAC.

The Change Agents continue to hold their monthly meetings and are growing in number each month! The Change Agent Orientation Committee will be holding their next orientation for new Change Agents on February 12th, 9 - 11:00, in the 1380 Howard 4th Floor conference room. Interested parties can RSVP to Lucy Arellano at 255-3687.

Zialogic will be here for their **Quarterly Training January 10th and 11th, 2007**. They will meet with the Change Agents Thursday, all day on January 11th at the Baha'i Center located at 170 Valencia Street, between McCoppin and Duboce (1 block from Market Street). Additional meetings with integration committees will be scheduled for January 10th.

7. **Awards.** The department would like to recognize Barbara Garcia and Manuel Vasquez for their contributions and efforts toward integration of services. On December 6, both Barbara Garcia and Manuel Vasquez were formally recognized at the Walden House Thirty Seventh Anniversary Graduation Event. Both, Barbara and Manuel received a community achievement Award for their efforts with promoting integration in the Behavioral Health Community.

Good Work and Congratulations!

8. **Comings and Goings:**

CEO Abner J. Boles, III, Ph.D. has named Donald Ivy Frazier as Deputy Director at Westside Community Services. Donald most recently served as the Chief Development Officer of Walden House, Inc., where he helped in agency expansion by identifying new opportunities and designing innovative programs. Donald will assist Westside in all areas of agency management and assume direct responsibility in Fund and Program Development, Contracts and Compliance, Quality Management, and Government Affairs. Donald also serves as President of the San Francisco Association of Alcohol and Drug Program Contractors.

Lorna Jones is the new CEO of Community Vocational Enterprises. Lorna has more than 20 years of executive management experience with federal, state, city, and private health and human services, and a dedication to providing quality mission driven services for mental health consumers. Lorna's educational background includes a Masters in Business Administration, a Masters in Education, Rehabilitation Administration, and a Bachelors in Liberal Arts, with a Spanish major.

Welcome and congratulations to Lorna and Donald!

9. **Other Upcoming Events:**

Motivational Interviewing in an Integrated Behavioral Health System – Dee Dee Stout, February 8 or 9, 2007, 8:30-5PM, Philip Burton Federal Building.

Safe Workplace Violence Prevention – Michael Arrajj, February 23, 2007, 8am-12pm, or 1pm-5pm, Philip Burton Federal Building

To register, contact Norman Aleman, CBHS Training Coordinator at 415-255-3553 or email norman.aleman@sfdph.org

Past issues of the CBHS Monthly Director's Report are available at: <http://www.dph.sf.ca.us/CBHS/default.htm> To receive this Monthly Report via e-mail, please e-mail kathleen.minioza@sfdph.org

1.1 Directors Report: Board Discussion

Dr. Moses: "There is still no residential care program in the southeast sector of the City. With all this new funding, why is this still not happening?"

Dr. Cabaj: "This a critical issue in the southeast sector. We are looking at a new urgent care center that more than likely will end up in the lower Mission. The trouble with the Mental Health Services dollars is that you can't use them for involuntary services. You have to use them for services outlined in the plan. Residential services were not ranked high or at all in some of the aspects of the plan.

People were so focused on getting more services to more people. We are always looking for new programs beyond Community Behavior Health Services: Housing and Urban Health, another division of the Department of Public Health. Mark Trotz is the head of that, and they are always looking for new sites and new housing. Because of the new Third Street streetcar, the worry is that property is going to get harder to afford. This would be a great window now. Let us know if a reasonable property comes along and we will work with Mark Trotz to get new funding. The Mayor's office is very interested in funding new housing. Most of it is focused on the central part of the City."

Dr. Moses: "I just think something should be done about it. There is nothing in Bayview. Maybe we can get someone to write a proposal."

Ms. Brown: "What amount is reasonable?"

Dr. Cabaj: "It takes about \$3 million to set up an urgent care program, and a residential care program would potentially cost more than that. And that's annually.

There is an ongoing work group that is looking at the health needs of the Bayview. This grew out of the special meeting of the Health Commission. Jacob Moody, Director of the Bayview Hunters Point Foundation is co-chair with Dr. Mark Ghaly, Director of the Southeast Health Center. They are working together, and you might want to contact Mr. Moody and express your concerns and that this is a high priority. They may want to put this matter in the set of recommendations."

1.2 Public comment relevant to Item 1.0

Ms. Maas: "My question concerns the Mental Health Services Act and the allocation of funds. Have all the proposals for prevention services been put through? The Native American Health Center submitted our proposals and we did not receive any funding with the first roll out, and we are concerned about the process for the second one. Has that been determined yet? And if not, what is the process? Is that something you can address?"

Dr. Cabaj: "I urge you to come to the meeting on January 31st. The first roll out was just the clinical services dollars. There were no prevention dollars in that. We hope to get guidance from the State by April concerning the second round of funding allocations. At that point, my belief is there will be a large community process in terms of ideas, and then the determination of how much each county will get, and if there will have to be an RFP process again. There will be a lengthier process than I had hoped, but you haven't missed anything yet."

Mr. Kalman: "Why was the budget for the second year of Mental Health Services Act so little, just \$5.3 million?"

Dr. Cabaj: "The allocation is decided by a formula determined by the Department of Mental Health. We've protested right from the beginning, and have gotten support from our elected officials like Assemblyman Mark Leno. The State says that the existing formula is legitimate, and that we have to live with what we get.

We still keep raising this issue. We will be getting about \$2.4 million more for the 2007/2008 budget. Again, that's not nearly enough. We got the second lowest per capita amount of any other county. Marin County was the only one lower than us. San Mateo County was the third lowest; so the three Bay Area counties got the short end."

Ms. Jackson: "When will the second time happen for RFPs when people can apply for funding?"

Dr. Cabaj: "It's a three-year cycle. The State allocated the funds a little bit late, so they might have added another year, but right now, all the RFPs were for one year with the possibility of renewal for two years. That's just the way the city structure is. So must likely, the program will continue for the next three years unless there is a major problem.

If we want to add new programs and they are not in the same type of services that we currently offer, we would do a new RFP, but there is no specific time as to when that would happen. If we get a new set of money, say for prevention, that would likely go out to an RFP, and there would be a whole new cycle of money for that. The City usually likes to do a one-year contract with a brand new program, with the option to renew up to three years."

Ms. Jackson: "The money for gang violence went to Insituto. Bayview and Sunnydale have high rates of homicide amongst the young. Will that money always stay with Insituto?"

Dr. Cabaj: "We were adding it to one more program. There was money put aside for one-time funds for the Westside organization, and they have a promise to work in the Bayview. As we get more money, one of the things we will probably ask for in the new budget is additional funding for violence response services throughout the City, especially targeting the Bayview and Hunter's Point area. We see this as one of the chief community areas of opportunity, so we will be asking for more money.

We believe the Mayor and Board of Supervisors will be very supportive of that, and we will see if the Mayor's budget will allow for additional expansion. If not, with any new dollars that come in, we will keep trying to allocate them to that area."

2.0 PRESENTATION:

PRESENTATION: DISPROPORTIONALITY TASK FORCE: Robin L. Love, MA, Family Preservation and Support Program Coordinator.

2.1 Presentation

Ms. Love: "I am the Family Preservation and Support Program Coordinator for the Human Services Agency, Department of Human Services, Family, and Children Services Division. I am also the day-to-day manager for the Disproportionality Project, looking at why so many African-American children enter into our foster care system; as well as looking at the disparate outcomes. Not only do those children enter at a greater rate, the outcomes for African-American children that enter our child welfare system are not as positive as we would like.

In November, I was pleased to come to the Board and give an overview of the planning process we engaged in, and some of context for why we began to do this work, and also talk about some of the recommendations. So, part of this follow up is designed for me to

share a little more information, for folks to ask more questions, and then maybe take time to brainstorm a little to talk about the issues, and go a bit deeper. Hopefully we can find ways that we can connect this Mental Health Board with our Foster Care Improvement Task Force, and some to the other activities that are going on. I would also like to talk about some of work we are doing internally in the child welfare system to begin to address some of these issues.

I'm open to move the discussion in a way that will be beneficial.

I'll briefly recap a little bit of the background of why we began to look at this issue. In 2003, we began looking at data about who enters child welfare, and what is going on with them. This work happened simultaneously with the State beginning to implement child welfare redesign and system improvements. There was a concern across the nation that child welfare as a system of really supporting and helping raise children was not doing the best job it could do. Children often got hurt in care, and children entering the system did not necessarily fare better because we engaged in their lives.

One of the poignant issues is the number of children of color entering the system. Across California and the nation, children of color are more likely to enter the child welfare system—African-Americans, Native Americans, Latinos, and Asian-Pacific Islanders. This was of great concern to folks, including those in child welfare.

In San Francisco, because this issue is a little more acute when it comes to African-American children, we decided to take a more in-depth study and do research, and begin to engage not only our child welfare staff, but the community, parents, and fathers, to begin to understand this issue. So, in November of 2003, we started an eight to nine month planning process. This was embraced by Supervisor Maxwell, because she was concerned that the majority of children entering the child welfare system come from the southeast sector of the City—94124, 94134, 94107: Portrero Hill, Visitation Valley, and Bayview-Hunter's Point.

With the help of Supervisor Maxwell, the Anne E. Casey Foundation, the Stuart Foundation, Cal State Hayward, and U.C. Berkeley, we worked on this planning process to really look at the issue, to collect information, and to also come up with recommendations. In November 2004, 'Raising Our Children' together was completed. At the last Mental Health Board meeting we talked about some of those recommendations in terms of where we wanted to go with the work.

One of the key recommendations, which I think is one of the questions the Board wanted to discuss, was having a public hearing on this issue. Working with Supervisor Maxwell, we had a public hearing where we released a report and people got a chance to share and give us feedback. It was also an opportunity for us to establish the Foster Care Improvement Task Force, a legislative body that would bring department heads and other key folks

together meeting monthly to provide not only governance and oversight of our work; but to also guide what's happening and to really work with our child welfare agency to support the kinds of initiatives and strategies, and child welfare practice that needs to occur to improve outcomes.

That is, in a nutshell, some of the work we did in advance. The task force started meeting two months ago in November. They meet monthly, the first Wednesday of every month. I can make sure that if folks want to get special invitations to the meetings, I can get that information to Ms. Brooke, and she can make sure you get your names on a list. They meet at the Bayview-Hunter's Point Foundation.

It's a representative group appointed to the task force. We have foundation and community folks, community-based organizations. We also have several department heads appointed to this task force to help us look at this issue. On our Department of Human Services website, the minutes and agendas, and all the handouts of the meetings we have held to date are there.

Today, given that there was such great interest in this issue, I wanted to come back and focus a bit more on the data, but to also brainstorm with you about what you think is important in terms of how the Mental Health Board can support us.

One of the reasons why the issue of African-American children entering the child welfare system is more acute in San Francisco is because we have the lowest child population of a city our size in the nation. When we talk about allocation of funding streams and resources, it impacts us that we don't have large numbers of children because often, allocations are tied to the birth rate in a particular city.

Over the last twenty years, San Francisco has lost almost half its African-American population. In the past, African-Americans made up roughly 20% of the population. Today, we think that African-Americans are hovering between 6-8% of the total population in San Francisco. The concern is that given the fact that we have very few children and such a small population of African-Americans that so many of these children are being raised in child welfare. We've also found that this is an issue with Native Americans, it's just that because the number of African-American children in the system is so large, the Native American numbers get dwarfed by this fact. We also have a disproportionate representation of Native Americans in the system as well. This is something we discovered as we began looking at the data.

Given that we have so few African-American children, there is a great concern that so many of them are being raised in child welfare. 52% of them are placed out of county. So in addition to bringing them into the system, we don't have enough homes for them in the City. It's expensive; so a lot of our children are placed out of county who are born and raised here; who have ties here. Sometimes when you hear the stories about teens who go AWOL, they are going back to their communities where they have ties, where they feel more comfortable.

When we started our planning process we realized that twenty years ago in the early 1980s, this has been an issue that has been going on in San Francisco for a very long time. It's not new to San Francisco. We've been tracking population data and child welfare statistics since about 1980. We actually identified two other studies done around this same issue years ago to begin to address it. So one of our main concerns was not create a new report, and do nothing with it. This is one of the reasons why I really wanted to support this work because I believe that this is something we need to look at and 'keep our eyes on the prize' about.

African-Americans are about 42% of the referrals. Of those, African-Americans are likely to be reported on, more likely to be assigned to a child welfare worker to do an investigation, more likely to be substantiated. Our process is to look for the victim. More than any other population, African-Americans seem to be looked at and substantiated more. The entries are higher, and the children stay longer in the system.

In comparisons to other ethnic groups, if we look at the next largest group—Latinos, we see that their entry into the system and their substantiation rates are pretty close in terms of the total population. What was interesting when we looked at this data, we found they were less likely to enter the system even though they get substantiated at a larger rate, and then for whatever reason, and this is what we are beginning to look at, they don't stay in care very long. These are immigrant children who may not necessarily have all the resources, or have their documentation in place. But whatever is going on with that community and the issues there, it seems that there is something happening where they are not staying in care. Whereas, African-American children are more likely to be raised in care, and be in care seven to ten years. We also see that the generational issues with African-Americans and other children of color are very prevalent. Meaning that we can pull the case file on the grandmother, the mother, and we probably have the daughter coming in soon. There is the chronic marginality where people just can't get out of this cycle, and something is going on that we really need to take a look at.

You can see that the numbers of African-American children entering the system are beginning to drop, not just because we are doing such great work but because the population numbers are dropping. Conversely, we see that the numbers of children entering the system for the next highest group are beginning to increase. The numbers for Latino children entering the system are slowly increasing.

Most of these families are poor; so socio-economic issues are major. Many of these children enter our system because of neglect, caretaker incapacity, and caretaker absence, as opposed to sexual or physical abuse. A lot of our families are engaged with other systems: Calworks, Juvenile Probation, Adult Probation, Mental Health.

Since 1988, African-Americans have always been the largest percentage of children entering the system, where other populations' numbers are closer to their overall population count. This is why we say African-American representation in the system is disproportionate to their total population count in the City.

In addition to larger numbers of African-American children entering care, they are more likely to re-enter the system once we return them home. Something is going on in terms of what we are doing to support families and our own practices to begin to address these issues. Though we place a lot of our children with relative caregivers, what this may mean is that we need to spend more time supporting the birth parents and working with the issues they have, so that we can have a better support rate of reunifying their children with them. We also need to hear from folks with your kinds of experience: what you understand about child welfare, your families that you work with, and the colleagues that work with families.

One of the other things we are also looking at is the timeliness of reunifying families. We have twelve months to reunify a child with their family. That is not a lot of time if the presenting issue is substance abuse, mental health, or poverty. We have to look at building a support system in this timeframe to help the family.

The largest percentage of allegations is neglect for African-American children. That is why we know that the traditional child welfare response may not be the best response, or the only response that we need to do to begin to address these socio-economic issues. A lot of these communities have violence. A lot of them don't have community resources and the support within the system. A lot of these families don't have access to the kinds of care and support that we have. The other thing is that because so many African-Americans have left San Francisco, all of their support systems are gone. The high cost of living in San Francisco is also having an effect on the systems needed to be in place to give support and care to these children.

Another issue the Board mentioned wanting to look at is who is doing the reporting on children. This is really important on how we work with folks around early prevention strategies. A lot of times it's the counselor, therapist, or the school. What we've found in those cases is that teachers see things going on, particular neglect issues way early, before they arise to the level of crises where we need to get involved. But often, they don't know what to do. They don't have access to resources. Our schools don't have the same enrichment services and counseling they used to have. Looking at who reports is really important to us in terms of how we set up our mandate and reporter training; how we help people do early identification, and more linkage to resources for families earlier.

These are some of the things we think about when it comes to practice. One of our strategies in addressing these issues is doing more work in the community: just good old-fashioned community partnership kinds of activities. People don't understand this issue. They feel it but they don't realize that so many of our children in the southeast sector are in the child welfare system. People tend to think about it in their own small world, but the collective community doesn't understand the crisis. This is really a crisis. When we do studies and see that the children who are victims of violence or perpetrators of violence, we find 60% of them were raised in the child welfare system. What goes on in the community greatly impacts these children. These kids need homes. The community needs to be educated on what they can do to certify their homes to accept these children.

The other thing I've noticed in doing the community work is that people don't understand our parameters as child welfare workers. We don't educate people about their rights. We don't engage people in a strength-based way. We are considered the 'baby snatchers'. Child Welfare is not considered the place where families can go to get support. What is ironic about this is that in the study we did, people will call us when they have no other place to go because they know they will get child care; they might be able to link up with other resources. I consider all of you our new community partners in terms of supporting this work.

Finally, one of the promising initiatives is our Differential Response, which says we will work with families differently. We will try to do early linkage to services to address some of the issues I raised based on the study and findings. Again, if it is socio-economic, as well as parental stress and substance abuse, we wanted to have a different response. This has been in service as a pilot program for eight months. This program allows us to begin to see the types of issues that come up as we connect with families early on in terms of resources we are providing. We are looking at supporting people with parenting, education and school issues, childcare, and after school care.

As part of this pilot, we've created an emergency fund to also assist community agencies and families.

Connecting with groups like the Board is really critical. I'll stop here, because I would like to hear your ideas on how to move to the next step."

Ms. Eichenbaum: "What do see as some of the next steps? How would partnering with different organizations like this one help you?"

Ms. Love: "One of the reasons the task force is so important to me is because it is that oversight governance body with big teeth that can take on the big guns. One of the things which are important, is helping keep our 'eyes on the prize,' saying it's not about the agency, it's about the children, quality of life, and the families. Helping raise awareness about this issue is important. Talking to your colleagues, your neighbors about the

disproportionality of children of color in the system would help greatly. We need people to think about how they can help, the families in particular.

These are two ways that don't cost a lot of money. This body can check in as to how the agency is working. Maybe one or two Board members can come and work with the task force.

Some of the things we are doing internally are taking a look at our welfare practices. This is not just about child welfare practice. National studies show that people of color are no more likely to abuse their kids than others. The reason why children of color come to the attention of the system is because of individual, institutional, and structural racism. We need to address the impact of racism on policy; how it plays out in the system. An African-American or Native American family may be tracked by the system, whereas a Russian or Caucasian family may not be tracked. We sometimes look at strengths in one culture, and see them as deficits in another. We often don't understand different cultures; so we put our own standards on other cultures without fully understanding the impact of this.

We have to look at racism. This is very difficult. Racism impacts on how you see yourself, how you see the world, and it's a very difficult issue to address; and it's not just a child welfare issue. We now internally are challenging ourselves to create spaces where we can talk about these things and figure out where we go from here in terms of looking at addressing the issue of racism. We have community programs where we are trying to look at their efficacy and fidelity practices in terms of this.

We don't have enough foster homes or parents. Maybe you can be a resource contact, checking in with families. There are years where we can't even recruit one family because of the difficult process, and people don't have the space or the funds. Housing is a real issue.

Finally, we are looking at developing a positive message campaign. The media portrays the issue negatively. There are a lot of good things that are going on. I would like to get ideas from you on how to raise the awareness of people as to the positive things people are doing in these communities. How do we tell the stories of families who are succeeding in spite of the odds against them, and use those as examples for other parents, and to change society's image about people of color, in hopes that others and the business community can come to support us."

Dr. Moses: "The statistics are alarming. How about the grandparents? How can we make money available to these grandparents who are caring their grandchildren?

You also talk about what we can do; have you looked at mentors, fraternities, and sororities for outreach?"

Ms. Love: "In addition to the 52% of our African-American children being placed out of county, the majority of them are placed with relatives; so we have a lot of grandparents.

The biggest contract we have to support them is Edgewood and they have a small kinship program. They do try to support grandparents.

Legislation was passed so that relative caregivers will now get the same rates of aid as foster parents. In the past, relative caregivers got less aid and support. In San Francisco we always tried to patch the discrepancy. We allocate so much of the General Fund to this issue, so we have been a little better than other counties; but now grandparents will get paid the same rate. Before, foster parents would get significantly more funds to raise a child that was not part of their family. The City Attorney is meeting with us to figure out how to implement this law.

At the same time, this legislation makes relatives have to go through the same rigor of licensing as foster parents. So at the same time we are creating parity pay for relatives, we are creating other hurdles for them to go through. As an agency, we are addressing this issue. We are working very hard to keep our kids with relatives."

Dr. Moses: "It's difficult to get all the stakeholders on the same page. What can we do to reach out to the grandparents who really do care?"

Ms. Love: "It comes down to good organizing. We have to recreate this. San Francisco is a hard city in which to do this. It's difficult to get all the stakeholders on the same page. We are willing to try in spite of this. We are open to new perspectives."

2.2 Public comment relevant to Item 2.0

Ms. Maas: "I want to thank you for mentioning the disproportionate numbers on Native Americans that we know exist in the system, but rarely hear about. A couple of things you mentioned that I feel would be worth looking at are community education and community advocacy.

When I talk about community advocacy, I am talking about the consumers and their families and education with respect to how history has effected the lives of individuals, families, and communities. We see the system as the oppressor, and we don't recognize our own internalized oppression. The gang violence that we see in our communities is a result of historic policies. We need to push for community advocacy and education in our communities.

Also, looking at the issue of institutionalized racism in our agencies is a key point you addressed. In particular, that the AFDC funds that were allocated during the Clinton administration, were shifted over to Child Welfare, and these families receiving AFDC aid have been criminalized in the child welfare system. These are issues we need to address and make them known in the broader community. They need to hear our voices and not have our voices silenced.

In the Native American communities, we also see the inter-generational cycle of children being in the system. I like what you said about recognizing what we have in common, our similarities, and the unification of communities and working together."

2.3 Further comments from the Board relevant to Item 2.0

Ms. Wright: "What are the ages of the African American children you serve?"

Ms. Love: "There are different age blocks. Right now we have a large amount of children who entered the system in the 80s, aging out of foster care. In a couple of years we will have fewer of them aging out, because we don't have many entering the system. We tend to bring in children aging from zero to eight."

Ms. Wright: "How are you helping children who are aging out of the system?"

Ms. Love: "We have procedures set up where a child who leaves the system is connected with a nurturing adult. We are now looking at the child's father's side for support. This is rarely done.

We have over 2000 children in care. The system struggles in helping children. Often, we silence people. We act on authority, not always in the best interest of the child. We are beginning to look at the outcomes of our procedures. We are trying to be more accountable, and letting families help in the decision process."

Mr. McGhee: "Thank you Ms. Love."

Ms Love can be reached at 415 557-5915 or Robin.Love@sfgov.org.

3.00 ACTION ITEMS

4.00 MENTAL HEALTH BOARD PRIORITIES FOR 2007

There was not a quorum, so no actions were taken..

5.0 REPORTS

5.1 Report from the Executive Director of the Mental Health Board:

Ms. Brooke: "The Mental Health Board website is up and running. Mr. Purvis and Mr. Hines worked very hard and provided the 'Frequently Asked Questions and answers.'"

5.2 Report of the Chair of the Board and the Executive Committee:

Mr. McGhee: "There was a great turnout for the Board Retreat. The format was very good. I would like to thank all the Board members for their participation."

Dr. Moses: "The husband of a close friend committed suicide on the Golden Gate Bridge. I would like to request that the Executive Committee look at bringing someone in to talk about the status of the bridge barrier. Maybe Mr. Hines can help with this."

5.3 Program's Committee Report: Rebecca Turner, Ph.D.

No report.

5.3a Planning Committee Report: Tom Purvis

Mr. McGhee: I will bring up the May event at the next Executive Committee meeting. The format of the event may change.

5.4 Budget Committee Report: James McGhee

No report.

5.5 Report by members of the Board on their activities on behalf of the Board.

No report.

5.6 New Business

Mr. Casados: "I wonder if the Board could look into finding out how applications are being handled for the ten thousand new housing units."

6.0 PUBLIC COMMENT

Mr. Kalman: "I thought the Board moved its monthly meetings to City Hall to be closer to government. Why is there no Board of Supervisor representation?"

Mr. McGhee: "Members of the Board of Supervisors have come and spoken. I will talk to President Peskin."

ADJOURNMENT:

There being no further business, the meeting was adjourned at 8:15 p.m.

SAN FRANCISCO MENTAL HEALTH BOARD



Gavin Newsom
Mayor

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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, February 14, 2007

City Hall

One Carlton B. Goodlett Place

2nd Floor, Room 278

6:30 p.m.

DOCUMENTS DEPT.

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CALL TO ORDER

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ROLL CALL

AGENDA CHANGES

02-14-2007: 5:45 PM

Item 1.0 DIRECTORS REPORT

For discussion.

1.1 Discussion regarding Community Behavioral Health Services Department Report, a report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.

1.2 Public comment relevant to Item 1.0

Item 2.0 PRESENTATION: New Directions in Supportive Housing, Richard Heasley, M.P.A., Executive Director, Alexandra Kutik, Chair of Marketing, Advocacy and Development Committee, Conard House

For discussion.

2.1 Presentation: New Directions in Supportive Housing

2.2 Board discussion of possible Board responses to the presentation.

2.3 Board discussion of future presentations and agenda items.

2.4 Public comment relevant to Item 2.0

Item 3.0 ACTION ITEMS

For discussion and action.

3.1 Public comment relevant to Item 3.0

3.2 Proposed Resolutions

3.2.a PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of November 8, 2006 be approved as submitted.

3.2.b PROPOSED RESOLUTION: Be it resolved that the notes of the Mental Health Board Retreat of December 9, 2006 be approved as submitted.

3.2.c PROPOSED RESOLUTION: Be it resolved that the notes of the Mental Health Board meeting of January 10, 2006 be approved as submitted.

3.2.d PROPOSED RESOLUTION: Responding to Critical Foster Care Issues and Concerns. (Attachment A)

3.2.e PROPOSED RESOLUTION: Be it resolved that the Mental Health Board commends Carmen Lee and Stamp Out Stigma. (Attachment B)

3.2.f PROPOSED RESOLUTION: Be it resolved that the Mental Health Board commends Behavioral Health Court. (Attachment C)

3.2.g PROPOSED RESOLUTION: Be it resolved that the Bylaws of the Mental Health Board be changed as attached. (Attachment D)

Item 4.0 MENTAL HEALTH BOARD PRIORITIES FOR 2007

4.1 Public Comment relevant to Item 4.0

4.2 PROPOSED RESOLUTION

RESOLUTION (MHB-2007-xx) Be it resolved that the following priorities be adopted by the Board for 2007 (Attachment E):

1. Develop new partnerships with other organizations in order to collaborate on mental health issues.
2. Lead and participate in education and advocacy efforts in identified legislative areas.
3. Provide education to San Francisco organizations and the community about critical mental health issues.

Item 5.0 REPORTS

For discussion and possible action.

- 5.1 Report from the Executive Director of the Mental Health Board.
- 5.2 Report of the Chair of the Board and the Executive Committee.
- 5.3 Planning Committee Task Force Report: Tom Purvis
- 5.4 Report by members of the Board on their activities on behalf of the Board.
- 5.5 New business - Suggestions for future agenda items to be referred to the Executive Committee.
- 5.6 Public comment relevant to Item 5.0

Item 6.0 PUBLIC COMMENT

Members of the public may address the Mental Health Board on any items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board.

ADJOURNMENT

DISABILITY ACCESS

- 1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Edwin Batongbacal at (415) 255-3446 (voice) or (415) 255-3449 (TTD). Five days notice before the meeting will help to ensure the presence of an ASL interpreter or sound enhancement system. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.
- 2. Meetings are held at City Hall, One Dr. Carlton B. Goodlett Place (between Grove and McAllister), in Room 278. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and 71 Haight/Noriega. Also, the J, K, L, M, and N lines underground. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.
- 3. City Hall is accessible to wheelchairs. Elevators, doorways, restrooms, and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on One Dr. Carlton B. Goodlett Place.

4. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City accommodate these individuals.

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The ringing of and use of cell phones, pagers, and similar sound-producing electronic devices are prohibited at this meeting. Please be advised that the Chair may order the removal from the meeting room of any person(s) responsible for the ringing or use of a cell phone, pager, or other similar sound-producing electronic devices.

KNOW YOUR RIGHTS UNDER THE SUNSHINE ORDINANCE

Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review. For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact:

Frank Darby
Sunshine Ordinance Task Force
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689
Telephone: (415)554-7724
Fax: 4(15) 554-5163
E-mail: soft@sfgov.org

Citizens interested in obtaining a free copy of the Sunshine Ordinance can request one from Mr. Darby or by printing Chapter 67 of the San Francisco Administrative Code from the internet at: www.sfgov.org/sunshine.htm

To view Mental Health Board agendas and minutes, you may visit the MHB web page at: www.sfgov.org/mental_health. You may also go to the Government Information Center at the Main Library at Larkin and Grove in the Civic Center. You may also get copies of these documents through the MHB office at 255-3474.

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Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance [SF Campaign & Governmental Conduct Code 2.100] to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; web site www.sfgov.org/ethics.



SAN FRANCISCO MENTAL HEALTH BOARD

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MENTAL HEALTH BOARD ATTACHMENT A February 14, 2007

PROPOSED RESOLUTION (MHB-2007-xx): RESPONDING TO CRITICAL FOSTER CARE ISSUES AND CONCERNS

WHEREAS, 2,200 San Francisco children are in foster care, and

WHEREAS, 70% of the children in foster care are African American, while only 8% of the City's population is African American, and

WHEREAS, too many children in foster care end up in the criminal justice system, and

WHEREAS, 24% of the San Francisco murder victims were previously in foster care, and

WHEREAS, 39% of the suspects committing the murders in San Francisco were in foster care, and

WHEREAS, the substance abuse rate is higher for foster care children, and

WHEREAS, the suicide rate is significantly higher for foster care children, and

WHEREAS, many Grandparents are assuming responsibility for caring for their grandchildren, and

WHEREAS, the potential for child abuse is higher in foster care, and

WHEREAS, 55% of foster care children receive mental health services, and

WHEREAS, children are being released out of the foster care system without needed support, knowledge, and vocational skills to succeed, and

WHEREAS, mental health care for children in foster care when they are young will save tax dollars in the future.

BE IT RESOLVED that financial support and mental health services for grandparents taking care of grandchildren needs to be available, and

BE IT FURTHER RESOLVED that transitional care for youth 18 and older who age out of the system such as: job training, housing, school vouchers, financial aid, transportation (muni passes), and family planning needs to be available, and

BE IT FURTHER RESOLVED that the trend of case load reduction for child welfare workers be continued so that appropriate oversight is possible, and

BE IT FURTHER RESOLVED that all children entering the Foster Care System need a mental health assessment and counseling made available.

SAN FRANCISCO MENTAL HEALTH BOARD



Gavin Newsom
Mayor

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San Francisco, CA 94103
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www.sfgov.org/mental_health

**MENTAL HEALTH BOARD
ATTACHMENT B
February 14, 2007**

**PROPOSED RESOLUTION (MHB-2007-X): COMMENDING CARMEN LEE AND
STAMP OUT STIGMA.**

WHEREAS, Stamp Out Stigma, founded by Carmen Lee, is a nonprofit organization that is dedicated to raising awareness of mental illness among the public, and

WHEREAS, Stamp Out Stigma, using panelists who suffer from mental illness, educates people about the experience of being mentally ill, and

WHEREAS, Stamp Out Stigma contributes to reducing the stigma associated with mental illness by showing the human side of mental illness, and

WHEREAS, Stamp Out Stigma has given nearly 1,000 presentations to diverse audiences over the past ten years, and

WHEREAS, Carmen Lee, its founder has won many awards including a Lifetime Achievement Award from the Voice Awards, and

WHEREAS, Stamp Out Stigma contributes to educating the public in the hope that it will lead to greater compassion and understanding by all.

THEREFORE, BE IT RESOLVED, that the Mental Health Board of San Francisco commends and thanks the Carmen Lee and Stamp Out Stigma for their years of dedication and commitment to educating the public about mental illness.

SAN FRANCISCO MENTAL HEALTH BOARD



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**MENTAL HEALTH BOARD
ATTACHMENT C
February 14, 2007**

**PROPOSED RESOLUTION (MHB-2007-xx): IN SUPPORT OF THE
BEHAVIORAL HEALTH COURT**

WHEREAS, far too many people with mental illness end up in the criminal justice system rather than in the mental health system, and

WHEREAS, these people with mental illness need treatment rather than punishment, and

WHEREAS, the Behavioral Health Court is proving itself to be a very effective and humane way to help mentally ill offenders get into treatment, and

WHEREAS, the Behavioral Health Court involves a multidisciplinary team and is an excellent role model for the coordination and integration of services across City departments, and

WHEREAS, the Behavioral Health Court helps keep clients from falling into the cycle of recidivism, and

BE IT RESOLVED, that the San Francisco Mental Health Board commends the City and County of San Francisco for creating and supporting the Behavioral Health Court, and

BE IT FURTHER RESOLVED, that the Mental Health Board commends the Superior Court of the City and County of San Francisco, and especially Judge Mary Morgan and her colleagues for their strong commitment to the Court and their compassion for the clients of the Court, and

BE IT FURTHER RESOLVED, that the Mental Health Board urges the City and County of San Francisco to make it a priority to increase funding and support for the Court, so the Court can increase the number of clients it works with.

SAN FRANCISCO MENTAL HEALTH BOARD



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MENTAL HEALTH BOARD ATTACHMENT D February 14, 2007

PROPOSED RESOLUTION (MHB-2007-xx): BE IT RESOLVED THAT THE MENTAL HEALTH BOARD AMENDS ITS BYLAWS AS RECOMMENDED BY THE EXECUTIVE COMMITTEE IN ORDER TO REVISE ITS ATTENDANCE POLICY.

ARTICLE III - MEMBERSHIP

The membership of the MHB shall at all times be as provided for in California Welfare and Institutions Code Sections 5604 et. seq., and San Francisco Administrative Code Sections 15.3 et. seq. This legislation includes a provision that a member shall be removed from office if he or she is absent from four meetings in one year. A leave of absence may be granted for up to ~~two~~ four months with prior approval of the Executive Committee. *In the case of medical illness, family emergency or other exigency, the Executive Committee may retroactively grant leaves as necessary.* If it is determined that a member has been absent from four meetings within a 12 month period, and no leave of absence has been granted, the MHB shall notify the Board of Supervisors in writing. Upon receipt of this notification, the position shall be declared vacant by the Board of Supervisors.

SAN FRANCISCO MENTAL HEALTH BOARD



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**MENTAL HEALTH BOARD
ATTACHMENT E
February 14, 2007**

**RESOLUTION (MHB-2007-xx): BE IT RESOLVED THAT THE FOLLOWING
PRIORITIES BE ADOPTED BY THE BOARD FOR 2007**

1. Develop new partnerships with other organizations in order to collaborate on mental health issues.
2. Lead and participate in education and advocacy efforts in identified legislative areas.
3. Provide education to San Francisco organizations and the community about critical mental health issues.



Gavin Newsom
Mayor

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UNADOPTED MINUTES

Mental health Board

Wednesday, February 14, 2007

City Hall, Room 278

San Francisco, CA 94102

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BOARD MEMBERS PRESENT: Rebecca Turner, Ph.D. (Chair); James L. McGhee (Vice-Chair); James Shaye Keys (Secretary); Bridgett Brown; Benito Casados; Jeanna Eichenbaum, L.C.S.W.; John Kevin Hines; LaVaughn Kellum King; Claudia Lebish; Toye Moses, Ph.D., M.P.H.; Tom Purvis; Jagruti Shukla, M.D., M.P.H.; Virginia Wright.

BOARD MEMBERS ABSENT: Bob Douglas, Esq; Kate Walker; Lisa Williams.

OTHERS PRESENT: Helynna Brooke (MHB Executive Director); Ayana Baltrip-Balagas (MHB Administrator); Dr. Eve Myer, Executive Director of San Francisco Suicide Prevention, Member of the Public; Rena Down, Member of the Public; Emeric Kalman, Member of the Public; Michael Wise, Member of the Public-Voices at Bay Newsletter/SFNMHC; Member of the Public.

CALL TO ORDER

The meeting was called to order at 6:30 p.m. by Rebecca Turner, Ph.D. (Chair)

ROLL CALL

Ms. Brooke read the roll.

1.0 DIRECTOR'S REPORT

Dr. Turner: "Dr. Alice Gleghorn, Deputy Director of Community Behavioral Health Services (CBHS) is here tonight to talk about the implementation of the Mental Health Services Act (MHSA) (Proposition 63), for which she has been responsible."

Dr. Gleghorn: "I'm sitting in for Dr. Cabaj tonight who is attending the California Mental Health Directors quarterly meeting and sends his regrets.

I wanted to call to your attention to a couple of things before moving on to Proposition 63. We received a Dependency Drug Court Grant about which we are very happy. It is always good news when we get some funding to serve people caught up in the criminal justice system. The grant is a little under \$300,000.

I am also responsible for CBHS integration efforts, and I have some announcements about trainings that we will be doing in this area. We are working closely with people who have both substance abuse and mental health issues, and trying to transform the system to be a more welcoming, and a more easily navigational place.

We are continuing to work on developing a response to Governor Schwarzenegger's proposal that all the funds allocated under AB 2034 be discontinued and covered by Proposition 63. He is saying that counties should allocate their own funds to cover AB 2034 programs using Proposition 63 funds. The counties believe that Proposition 63 does not allow for this to happen.

AB 2034 is the basis for the full-service partnership programs that are covered by Proposition 36. Half of our service funding needs to go to these types of programs. In the Governor's proposal, he is cutting the funds that are currently supporting AB 2034, saying that Proposition 63 funds need to cover these programs. He wants to move AB 2034 funds into another channel of funding for another type of program. By doing this, the Governor is saying he has not violated any laws. The counties vehemently disagree with him, and are organizing to object to this proposal. The Mental Health Association has put together a nice summary of what they feel should be written covering the issues, if you want to write a letter of protest to the governor.

If this were to come to pass, and San Francisco needed to take Prop. 63 funds to cover our AB 2034, it would basically wipe out close to \$2.5 million that we were already allocating to existing programs."

Ms. Brown: "You can't use Proposition 63 funds for existing programs."

Mr. Casados: "What I learned at the last MHSA meeting is that the programs funded by Proposition 63 are being successful, and we want to keep the funds allocated to them to promote their success."

Dr. Gleghorn: "We believe that the Governor's proposal is in violation of the Mental Health Services Act. The more he hears that people are upset about this, and that his actions are not in keeping with the original principles and ideas of Proposition 63, the more difficult it will be for the Governor to carry through with his proposal."

Ms. Brown: "Call his office?"

Dr. Gleghorn: "Call, write, email."

Mr. Hines: "Has the Governor violated the laws?"

Dr. Gleghorn: "He says no, the counties think yes."

Mr. Hines: "Do you know that he has?"

Dr. Gleghorn: "The proposal he has put forth, we think is supplantation, he has made a case that he thinks it is not. I'm not a lawyer.

One of the items related to Proposition 63 is one I am very excited about. We were able to fund the Office of Self Help at the San Francisco Study Center. This is a program that runs a peer support line and is operated by trained mental health consumers. With the funding, they are able to expand their hours of operation and their linguistic capacity. They are now open seven days a week. In addition to expanding their hours of operation, they were able to expand the help line.

We've begun to enroll clients into our Full Service Partnerships (FSPs). We've started Full Service Partnerships in three different adult settings and one child setting.

We have Housing Support Services (HSPs) for people enrolled in our Full Service Partnerships. We don't have housing for all of the clients, but we have opened eleven stabilization units at four hotels and we have filled five of those units at this time. We will also be opening some permanent housing units.

We also have some specific housing units for transitional age youth. Eight units for youth in the Full Service Partnerships, and ten units for youth who are not in these partnerships but who are homeless or in need of support. These units are already open and we have four youth in them now."

Mr. Keys: "I think that the HSP services sound fantastic. Having eleven units in the city is nice, but I am little concerned with follow up, follow through, and wrap around services for people who move into these hotels because the other tenants may pose a distraction for people who are trying to change their lives.

I would hope that the services that are being provided allow these people to use the temporary housing as a stepping stone."

Dr. Gleghorn: "The Housing Service Partnership is working with the Full Service Partnership. Everyone that moves into one of those units has the full wrap around services. We continue to have the case management and other activities provided to these clients.

Last month we sent staff from each of the Full Service Partnerships to The Village in Long Beach which is the model for AB 2034 and for the Full Service Partnerships themselves. It was a very good experience for the Full Service Partnerships to see the kind of team that works with every partner in helping them achieve their goals. These teams work with the partner to have a more meaningful life. This is the model we are using, and the Housing Support Services is just a little part of these Full Service Partnerships."

Mr. Keys: "Thank you for the clarification."

Ms. Brown: "Where are the consumer jobs being posted? Do they need a referral to get into the transitional housing?"

Dr. Gleghorn: "You can contact Larkin Street directly concerning the transitional residential housing. The youth need to have a serious mental illness and they need to verify that they qualify for the housing. We intend that these units be what they say—transitional for a short period of time, six to eight months until they can get a sense of how to get their own place and function without a lot of support."

The Housing Service Partnerships associated with the Full Service Partnerships is a referral process that goes through CBHS. The Full Service Partnerships are designed for clients who have had difficulty accessing mental health services in our system in the past. They have either never been served, or they have been underserved.

Ms. Brown: "Where are the jobs being posted?"

Dr. Gleghorn: "Every agency that got MHSA funding, and most of these are contractors, were required to describe how they were going to hire peer employees as part of their application. Every single one of these agencies should be hiring staff. We have asked them to send us copies of their job announcements for display and circulation at CBHS."

Mr. Purvis: "Could you speak more about CBHS' role in the Drug Court?"

Dr. Gleghorn: "I'm assuming they are going to be able to hire staff that will work more closely with clients, but I don't know what type of staff positions or exactly what services they will be able to provide. It is a more intensive level of supervision and assistance."

Dr. Shukla: "In addition to distribution of money to various clients, has money been used for developing a better communication infrastructure between agencies?"

Dr. Gleghorn: "Within CBHS, we're hiring MHSA implementation specialists. We are going to be able to bring six people on board, and I've just made offers to five, and I'm waiting for final information on the sixth. One of the tasks they will be working on is helping improve communication between the agencies and helping transform the system overall."

We're looking at improving system navigation. We will be able to help people who are struggling to connect with different parts of the system, and they will have someone to call if the connection doesn't happen three weeks down the road. We're trying to change the system by at least getting our MHSA funded programs to talk to each other, and refer to each other in a way that we really haven't done before."

Dr. Shukla: "I think a lot of duplication of work can be avoided if there is a more sophisticated way of coordination in place. This might require more than having just a peer support work setting."

Dr. Gleghorn: "Another way that this issue may be addressed is the implementation of electronic health records. We are moving forward with this plan.

Dr. Turner: "Can you give us an example of any innovative tactics that may be happening as a result of this funding—an idea on how there is a real difference in terms of how we deliver services?"

Dr. Gleghorn: "Though what I'm talking about may seem small, having been in the system for nearly twelve years, I know how difficult even these small changes can be. The creation of the Full Service Partnerships and following the models that have been set by The Village, and Proposition 63 are examples of our looking at implementing new practices.

Another new practice is the hiring of consumers. This is a brand new territory for many agencies. The whole idea of including personal experience with the mental health system on the job description, saying to people we value your ideas is very different. Mr. Casados was on our interview panel. We had questions in our interviews saying tell us about your individual experience and how you think it will to help you in doing this position. One got points for that. The more one could describe how their experience could help them in the job, the more points they got. Hiring people on this basis is very new for the system. It's not going to be an easy change, but it is an important thing to do."

Mr. Casados: "I sat through fourteen interviews and I was surprised by the level of understanding that clients brought into the meetings that were totally different than what staff would have thought of. There is a vast knowledge that can be tapped and used in the system that cannot be held by a professional who has gone to school and learned about mental illness. I have an education, but the experience I heard from some of these people left me floored."

Mr. Keys: "I want to echo what Mr. Casados is saying by giving a small example of my own experience assisting in Supervisor Daly's office. I'm a member of District 6 and I know the system from being homeless to where I am today, and I brought that very same knowledge to his office, and can't believe what a difference it has made to have someone who actually knows what's going on in the community. He and his staff value my input on almost a minute-by-minute basis and I handle the constituent issues with no problem at all. I've been there for nearly two years and I am a valued member of the team. I can't say how much I appreciate seeing Mental Health finally get to a point where they value the experience of people outside the formal education sphere."

Dr. Turner: "Are there any more questions for Dr. Gleghorn?"

Dr. Gleghorn: "I think I'm coming back next month, so if you think of other things, you will have another chance. We're always available, so give us a call and we are happy to answer questions any time."

Dr. Turner: "Thank you for being here Dr. Gleghorn."

Below is the full Director's Report.

Monthly Director's Report

1. **Dependency Drug Court (DDC).** Community Behavioral Health Services (CBHS) has received a competitive grant award of \$287,177 from the California Department of Alcohol and Drug Programs to establish a dependency drug court (DDC) in the family courts. The DDC is a new collaboration of DPH, Superior Court and the Human Service Agency/Child Welfare Services. Parents who have been served with a child abuse or neglect petition and who have an alcohol or other drug problem will be eligible the specialized court. The objectives of the program are to achieve good alcohol and drug treatment outcomes, reduce child out of home placement time, reduce time to family reunification, reduce the incidence of failed family reunifications, and to stabilize families into long term supportive networks and housing. The state intends this to be a recurring grant, with no expiration date.

2. **MHSA Expands Peer Support Line:** The Office of Self Help will extend their hours for their Peer Support Line as part of the expansion of their services through funding from the Mental Health Services Act in cooperation with CBHS. This "warm line" provides emotional support to callers, and is staffed by trained mental health consumers who provide a compassionate ear and can offer referrals. It is now available 7 days a week and includes services in English, Spanish, Tagalog, and Cantonese. The phone number is 575-1400 - ask for Peer Support. The available languages at the Peer Support Line are scheduled as follows: English - 7 days a week; Spanish - Wednesday thru Sunday 1:00 pm till 8:30 pm; Tagalog - Sunday thru Thursday 11:00 am till 4:30 pm; Cantonese - Wednesday thru Sunday 1:00 pm till 8:30 pm. (The Peer Support Line is not a crisis line. If you are in crisis or feeling suicidal, please call 24-Hour Suicide Prevention Line at 781-0500.)

3. **Mental Health Services Act (MHSA) Update.**
The MHSA Advisory Committee will be meeting on Thursday, February 22, 2007 from 3-5pm, 1380 Howard Street, 4th Floor Conference Room. The next MHSA Community Forum will take place on April 25th in the Mission Neighborhood. About 50 people attended the MHSA Community Forum in the Tenderloin in January. The MHSA Advisory Committee meets bi-monthly to review MHSA implementation activities. The following section summarizes current progress.

COMMUNITY SERVICES AND SUPPORTS GROWTH FUNDS

MHSA – FSP SERVICES:

Thirty-five partners have been authorized to receive full service partnership services. The table below shows the age group of these clients and agencies where they were referred:

MHSA FSP Client Authorizations

Fiscal Year 2006 - 2007

AGENCY	Age Group	Nov-06	Dec-06	Jan-07	Total
UCSF Citywide Case Management	Adult		3	1	4
Family Service Agency	Adult	1		2	3
Hyde Street Community Center	Adult	7		3	10
Seneca	CYF		18		18
Total		8	21	6	35

Four partners have been identified for TAY services. Their cases are being reviewed prior to authorizations.

MHSA – HSP SERVICES:

Final negotiations are underway with the Housing and Urban Health (HUH) Direct Access to Housing (DAH) Program to provide 20 permanent housing units to adult and older adult full service partners. HUH has also identified 11 stabilization units at four hotels within the City to temporarily transition partners from homelessness. These stabilization units are available to partners for two weeks, with options to renew while the permanent housing is being secured. Five partners are in stabilization units.

Larkin Street Youth Services will secure 8 housing units for the TAY full service partners. These housing units will be equally divided between the two TAY- FSP agencies, Larkin Street Youth Services and CBHS-TAY unit

TAY Transitional Residential Housing

Larkin Street Youth Services have set aside 10 units for transitional residential housing and have already placed 4 youths in these housing units.

PEER HIRING

CBHS 9924 Positions:

14 applicants were interviewed in December and January for 6 positions as MHSA Implementation Specialists. Recommendations have been made to Human Resources and we are compiling the final paperwork to complete the hiring process. CBHS will be working closely with the Mental Health Association of San Francisco to provide on-going training and employment support for these positions.

PEER SUPPORT LINE SERVICE

The Office of Self Help will be extending the hours of the peer support line until 8:30 p.m. Wednesday through Sunday evenings as part of their expansion funded by MHSA. In addition, the support line will now be available seven days a week, with staff who speaks English, Tagalog, Cantonese, and Spanish.

PEER AND STAFF TRAINING SCHEDULES

February

February 8 and 9th

Motivational Interviewing in an Integrated Behavioral Health System is designed to focus basic to intermediate MI techniques.

February 23rd

Safe Workplace Violence Prevention is a one day two session intensive training day outlining critical methods and techniques on deescalating aggressive behaviors. This training will be conducted as a workshop, and dialogue will be encouraged and instructive.

March

CBHS is currently working in developing a training curriculum with the Mental Health Association of San Francisco to address the complex issues based around Depression. Mindfulness Depression will assist and help those individuals manage this issue. The training will be aimed at participants of the CBHS Peer Intern program and other consumers who are interested. We plan for 20 individuals to participate in this training.

We're also in the midst of working with Inspired at Work to provide training for newly hired consumers. Topics are: Recovery and Wellness Practice, Role expectations, Personal Wellness (Learning the WRAP), Documentation, Boundaries and Ethics, and Communication Skills.

DATA & EVALUATION

Data Collection and Reporting (DCR) update: The rollout of the web-based State DCR system (which collects data for the FSPs) has been delayed due to technical issues. The Performance Outcomes and Quality Improvement (POQI) unit of State Department of Mental Health (DMH) is now projecting that use of the enhanced web-based DCR will begin in March. Given the fact that programs are beginning to provide services, the MHSA workgroup decided that providers should use the paper outcomes forms in the interim so that client data is not lost. Copies of the forms are being distributed to providers.

Non-FSP evaluation: A memo has been sent out to inform non-FSP providers about the local MHSA evaluation. We are scheduling site visits to learn about the programs with the goal of establishing a process and outcomes evaluation framework unique to each program. An interview protocol has been created to guide the site visits. We have currently completed the initial site visits with two programs. CBHS Training staff has been part of the site visits and are assessing programs' training needs, including needs related to hiring, supervising, and supporting peer staff.

Tracking consumer involvement: Research and Evaluation staff has created a questionnaire to ask MHSA programs about issues that come up in the hiring and supervision of consumers in staff roles.

4. **CBHS Integration.**

The Change Agents will be celebrating their 2-year anniversary this month. To celebrate, they will be holding their monthly meeting on February 22nd. Interested parties can RSVP to Lucy Arellano at 255-3687. In addition to their monthly meeting, the Change Agents will be visited by Dr. David Mee-Lee to conduct a workshop focused on: Stages of Change and interventions appropriate to the System of Care; working with families and engaging them in services; and how to move forward with integration at the frontlines of care.

Zialogic will be here for their **Quarterly Training on April 13, 2007**. They will meet with Integration Committees at 1380 Howard Street, 4th Floor Conference Room.

5. **Other Upcoming Events:**

Addressing Domestic Violence Issues within an Integrated Behavioral Health System - Lisa Polacci, MSW and Nora Webb, MFT, **March 2nd**, Philip Burton Federal Building.

Tools Needed for Clinical Supervision - David Mee-Lee, MD., **March 19th**, location to be determined.

To register, contact Norman Aleman, CBHS Training Coordinator at 415-255-3553 or email norman.aleman@sfdph.org

Past issues of the CBHS Monthly Director's Report are available at: <http://www.dph.sf.ca.us/CBHS/default.htm> To receive this Monthly Report via e-mail, please e-mail kathleen.minioza@sfdph.org

1.1 Director's Report: Board Discussion

Dr. Turner: "I did want to let you know that the State has selected several programs that have begun implementation of Proposition 63, and San Francisco was selected as one of them. They are going to interview me on March 7th, and they asked me to recommend others; so I've asked Mr. Casados, and I'm going to ask Michael Medema because they have been very involved. Ms Brown, if you want to do an interview as well, it's for one hour and will be held at Howard Street."

Ms. Brown: "Will you please email me the information?"

Mr. Hines: "What is this interview?"

Dr. Turner: "The State is doing a study of various counties that have already implemented Proposition 63. They are going to ask us a number of questions which we have been given in advance."

Ms. Brown: "I would like to be a part of it."

1.2 Public comment relevant to Item 1.0

Mr. Kalman: "What I would like to know is why can't Proposition 63 funds be used to reactivate the Mental Health Rehabilitation Facility (MHRF)? I have heard no report from anyone in Mental Health concerning what is going on with the MHRF."

Dr. Turner: "We will pass your question on to Dr. Cabaj. The Board cannot respond at this time. Thank you for your comment."

2.0 PRESENTATION:

PRESENTATION: 0 PRESENTATION: New Directions in Supportive Housing, Richard Heasley, M.P.A., Executive Director, Alexandra Kutik, Chair of Marketing, Advocacy and Development Committee, Conard House.

2.1 Presentation

Mr. Heasley: "Let me start with thanking the Mental Health Board and Dr. Turner for the introductions, and for setting up all the components that have brought us here tonight.

It has been a while since Conard House has been in front of the Mental Health Board; so we are going to make an assumption that though you may have heard of Conard House before, we are going to update you as well as introduce what we do.

I'm going to let Alex Kutik do the first part of what we want to present tonight. It's very nice to be here."

Ms. Kutik: "I want to introduce you to Conard House. We have 115 staff and 80 part-time and temporary part-timers, many of whom are our clients, and 70 board members.

We provide an integrated and comprehensive continuum of resources—human and internal resources. Our programs and services are for adults with severe chronic mental illness, concurrent substance disorders, and other conditions.

Our facilities are located throughout San Francisco. In your packet you have a map of our facilities, our annual report, and data that quantifies the people we serve. You also have our website address.

We've instituted a system that we call Supported Self-Management. Our resources have been focused primarily on supportive housing. 70% of our support and income goes to that program. It provides an essential element of recovery, a safe and affordable place to live.

Conard House is preparing to celebrate its 50th anniversary of service to San Francisco. I realized that I recently passed the 50th year of my living with serious mental illness.

I was ten years old when my mother was hospitalized and diagnosed with manic depression. Twenty-five years later so was I.

In the 25 years since my diagnosis, I have spent five of those years unable to function productively. I have struggled to:

- o Overcome denial and shame;
- o Commit (only recently) to life-long treatment; and
- o Gain insight into my responsibility for my actions;
- o Move from acknowledgement to acceptance of a serious, chronic mental illness.

This struggle continues – one day at a time.

My successful 30+ year career in nonprofit management and consulting, in combination with family history, came to the attention of Conard House 18 months ago. I accepted their invitation to join the board of directors, with a personal goal of adding my voice to the public discussion about the resources needed to make a difference in the lives of people like me.

My participation tonight on behalf of Conard House is only the second time I have disclosed my disability in a public setting – the first time was last November at Conard's semi-annual public board meeting. Individual comments then and almost without exception mentioned my 'bravery.' These folks included board members, mental health professionals and family members of other consumers. That term made me uncomfortable, until I realized that those saying "brave" were assuming society's moral judgment and stigma. For me, speaking out is a necessary part of acceptance and recovery.

Shortly after joining the board, Conard House had a board/staff retreat. In introducing myself, I shared the realization that the only difference between me and the people we serve is that I am lucky enough to have available and accessible resources – a home, education, job skills, health care and most essentially, supportive family members and friends, people who care, people like you.

As KQED's director of strategic planning, I led a six-month process involving 400+ board members, staff and consultants. Conard House's recently completed process, led by Richard Heasley and me, was more intense, shorter by 2/3, and more compelling. I am recalling a galvanizing moment that signaled a fundamental shift in the dynamic of the essential relationship between staff and client.

- o What we are calling Supported Self-Management consists of pathways of compassion, hope and empowerment and doorways to the larger world outside serious mental illness to the life of the person living with it.
- o Like most of us, our clients gain power and control over their lives through access to meaningful choices and the resources to implement those choices. In our supportive housing program, Conard House offers a range of choices designed to support the varying needs of our clients for independent living in the least restrictive conditions.
- o Similarly, Conard House has dedicated its resources to programs such as employment, money management services and to increasing the capacity of our staff to support our clients' self-management.

The summary of our 3-year plan states: 'With the adoption of this plan, the Board of Directors and staff of Conard House are affirming that people in this community can and do self-manage their mental illness. Our role is to help them manage better.'

Our recast mission became simpler and broader. Rather than specifying the programs and services intended to help people, we are developing resources that help people self-manage mental illness. Resources are now more broadly defined; the dynamic clearly expressed.

Our vision is a sufficiency of sustainable resources – both tangible and deeply personal – that help our clients, our staff and our organization in their difficult work. Clients and staff share the need for internal resources – inner goals, resilience, insight, self-discipline and hope – in order to persevere, to succeed. Tangible resources work as incentives for our clients to look ahead and see a better life – safe and affordable housing, employment, healthcare, social integration.

This planning process led us to a strategy of transformation – first and foremost of the essential relationship, partnership, between clients and staff to focus on the process of recovery. Seeing people as whole persons, not simply as their labeled identity of mentally ill, is integral to this process. Similarly seeing Conard House in all of its human resources, programs, services, facilities and treatment approaches is integral to its organizational transformation.

I began by referencing Conard's years of service. That service has been sustained by innovative responses to the shifting tectonic plates of public policy and resource allocation and re-allocation. Richard Heasley, Conard House's executive director for more than ten years, can talk more specifically and eloquently about how that shifting ground brought us to the present, where it's moving us and what our plans and strategy for the future mean for our community."

Mr. Heasley: "This strategic planning process was in my estimation probably the only real strategic planning process I've ever been through, and I've been through a lot of them. What made it different was that we spent a very intense period of time going back and looking at some basic assumptions as to why we are in this business—as clients, as staff or board members. Part of this processing is recognizing that we are still responding to a set of broken promises.

I remember the community health movement of the 60s and 70s, and the belief that there needed to be an alternative to institution, and Ronald Reagan started closing the state hospital and sending people back to their counties, people found there was nothing in place to support these people. The supervisors of every single county were caught flat-footed because of the broken promise to not only have the people return to the community, but there were supposed to be the State resources coming back to the community to provide for essential services right there. This did not happen. A lot of scrambling went on in the 70s to prepare for the people/clients coming back to the community.

How did that promise get made and broken at the same time? What allows public policymakers to make promises like this and not fulfill them? There are no real answers to these questions, but I know what was on the minds of the people on the ground, either as clients or organization leaders who were trying to do this. I worked in trying to put together those first resources from the ground up. At that time I was working in Alameda County.

In San Francisco things happened a little differently. Hunter House opened its first halfway house ten years before all this began to happen in a big way. Elaine Nickels, a state social worker had the idea along with her mentor Hunter Reiner, that places were needed for people who were leaving hospital centers. Our flagship, Conard House in Pacific Heights, which is still operating is San Francisco's, and we think California's first halfway house. This is back before anything else was in operation. Twenty-five people moved in and all of sudden there was a program in place. The City and County of San Francisco was providing initial staffing. And it is still going on today.

It didn't take very long for the people who started this program to realize that a halfway house wasn't enough to address the problems that were arising from the return of patients/clients to the communities. After people completed the halfway house's programs, where were they to go? Within three years we opened what could be called a three-quarter-way house, which in effect were some co-op apartments. That was actually the beginning of what is called supportive housing; so we've been in the business of supportive housing since 1963.

Now that this approach has been discovered by the rest of the world, it has become everybody's answer to almost everything. There is one problem with that, and that is that the same calculus used for the funding of the two-step process implemented in the 70s is still being used to determine the allocation of resources today. Later on, after the start of this process, there was a period of time when very little was happening to get the system of care to grow locally for people actually living in supportive housing.

So when the Mental Health Services Act was being conceived, it was the original problems of community mental health way back in the early 70s that were being restated again for the very first time at this fundamentally different level, and it is right in the legislation, right in all the materials coming out of Sacramento. All the people working on this, Darrell Steinberg, all the folks from SCIU, and all the folks up and down the State who had been around and were helping craft the language of this legislation, were echoing the same promises that had been broken years before.

It was somewhat coincidental that even though some of us were involved in the development of Proposition 63, that the Conard House strategic planning process actually went back and without referring to the Mental Health Services Act, came up with a whole set of things we valued. These were pretty much the same things that Proposition 63 was putting value on.

The idea is that clients should define and determine how they are going to live their lives apart from their diagnosis; they ought to live in communities instead of institutions; they ought to be in least restrictive settings; they ought to be able to experience mental illness without stigma and shame; and recovery, to a large extent is possible.

The hard part about this is that we have systems of care that have been disincentives to the recovery process. As we were developing the strategic plan, this issue of the disincentives was something that we agonized over. What are the disincentives? People are afraid of a whole lot of things about the mental health system, because if one improves too much, and loses the medical necessity, there goes the SSI, MediCal, and other services. If the client has thought about getting a job, these services again are at risk."

Mr. Keys: "I see that you have nine houses in District 6 which is known for having a disproportionate amount of people with different types of personal issues—mental illness, disabled, elderly, HIV/AIDS—what is the level of experience of your management in these buildings, and what types of supportive help do they have to deal with this population?"

Mr. Heasley: "Our staff is actually divided into two. We have a property management staff that is run by a man who is a director of real estate, who has a real estate license, and is a certified property manager. He has a staff of property managers. We also hire outside property management companies for some of our buildings because of the underlining regulatory agreements. They're responsible for putting the lease in place. This is permanent housing. We don't do transitional housing anymore except in one building.

That's the property management side. The other side, we are doing supportive housing with a very heavy emphasis on outpatient services. We have a MediCal certification. Our staff includes people with credentials. Our Clinical Director and Director of Clinical Programs are both licensed psychologists. After that, we rely less heavily on people with professional degrees than we do with people who actually have a lot of experience and ability to engage people where they are."

Mr. Keys: "So in each of these buildings you are saying you do not have a member of staff or supportive staff who is able to deal with the different types of problems the residents may have."

Mr. Heasley: "We actually have people on site. Most of these buildings include a program director, sometimes a senior case manager, and then as many case managers as our contract provides for."

Mr. Keys: "What type of education or experience do these staff members have?"

Mr. Heasley: "Some Master's degrees, some Bachelor degrees."

Dr. Turner: "What are you looking for Mr. Keys?"

Mr. Keys: "Generally when people call into our office, and complain about their living conditions, there are several management companies that come to mind, and Conard House happens to be one of them."

Mr. Heasley: "We have people who have filed complaints. That happens all the time. A lot of them have to do with issues of the particular building, their neighbors, conditions on the street, outside dealers trying to penetrate the building; they have to do with everything you can think of. This is like any other situation where you have from 50 to 100 or more people living in a facility. I'm not saying we don't have people who have legitimate complaints, but we also have people who have perpetual complaints.

We have a system of dealing with that—comment cards, a protocol, written responses, and we have, to the best of my knowledge, never failed to respond to a complaint of anybody living in our buildings. We also have a lease enforcement policy where if we need to give notice to individuals living in the buildings because they are breaking the house rules and are violating the lease, we move against them. They have lots of support on the program staff side to help them maintain their housing, while people on the property management side are enforcing the lease, trying to provide quiet enjoyment for everyone in the building. So we don't shirk from complaints. We deal with them head on."

Mr. Hines: "If it weren't for Conard House, I wouldn't be sitting in this room right now talking to you today. I also want to say that I understand your point Mr. Keys. There are complaints in any building in this country, let alone this world.

I was in Conard House for a while, and the people working there treated me with the utmost respect. They didn't treat me like a mentally ill person. When you live with so many people with mental disorders there is going to come a time when a disagreement may occur, and that disagreement may result in a complaint.

I would like to say that I commend and thank you [Conard House] for coming today."

Dr. Moses: "I'm very familiar with your program. Could you breakdown geographically where most of your clients are coming from?"

Mr. Heasley: "We're getting referrals from the placement team, and that doesn't tell us what the client's home of origin is. There are heavy concentrations in the Western Addition, Bayview, the Mission, and Chinatown. In terms of diversity, 52% of our clients are persons of color. Within that, there is a large distribution of African American and Asian, and a fair number of Asian language speaking clients.

In terms of the diverse breakdown of the staff, it's running parallel to the breakdown of the clients."

Mr. Casados: "I have lived in your Plaza Apartments for a year. Initially, I had concerns but over the year I have been impressed with how the property managers have handled issues. I must commend your staff as well because they have been there for people when they have really been needed."

Mr. Heasley: "Glad to hear that."

Ms. Brown: "Is your money management program a paid service?"

Mr. Heasley: "Yes."

Ms. Brown: "Does the person have to be identified as psychiatrically disabled to use the paid service?"

Mr. Heasley: "There are two parts to that. If you are living in one of the supportive housing facilities, all residents have access to the financial services, whether you are identified as a CBHS client or not. In the community service settings, which are a contract we have with the Department of Human Services, a lot of the people have an Axis I or Axis II issue. Most of them are not hooked up in the system at all mainly by choice. They do not want to be identified as clients of the Mental Health System because they are self-managing their lives quite well.

I would like to shift back to the issue of Supported Self-Management, which for us is the centerpiece of everything we do, and it is the centerpiece of everything we are going to be doing with our strategic plan, over the next three years. It has also been the strategy that we have been doing all along.

Instead of these lists of services that are available, the idea is that there is nobody who understands better what is going on in their lives than the client. They are the experts. The question is how do you get experts to do two things: have enough insight as to what's going on in their lives so they can self-manage better, and how do they come to understand things to aspire to and to have things to hope for beyond their immediate living situation? We are very glad that the Housing First Program came on the scene, but we were also very concerned that *housing first* would be seen by many as *housing last*.

One of the things we are working on in the strategic plan is *housing next*. Even though people have a lease that entitles them to permanent housing, a lot of the permanent housing/supportive housing settings are not the best place for some people to be. If we could work with people to identify other supportive housing settings—less restrictive, different economics, different locations not concentrated in the Tenderloin—that there are other less expensive ways of maintaining oneself in smaller living groups that are just as viable economically as the larger buildings of supportive housing.

As time goes on, supportive housing seems to be getting larger. There is a big concentration of people who have some very difficult issues and what we actually are not supportive of are buildings that have 100% people who have a primary mental health diagnosis. We think that incentives can be put in place and one of the things we are really keen on is *housing next opportunities*.

We are looking for support in three areas in our strategic plan—the Supported Self-Management Steering Committee; the Housing Next Steering Committee, and what we are calling Work Sights. We are looking for ways of helping people to work for the first time if they haven't been working at all. The idea is moving people from doing nothing to volunteering, from volunteering to part-time work, from part-time work to full-time work, and actually beginning to think about leaving the system. We actually have people working for us who have done this. We know this can be done. We know that given the opportunities, people will respond.

We are not expecting funding from the Mental Health Services Act. MHSA does not speak to the 1800 people we are currently serving. It is serving people who have not been served by the system before. Dr. Gleghorn addressed this. We actually think that the support for our services needs to come from the private sector. We want to champion the idea of Supported Self-Management and put it out there because we feel that people are struggling with how to do what we do better. People are already doing good things, but the question is how do you thrive, how do you move to the next step, how do you maintain hope, how do you embrace the themes of recovery?

We're not abandoning the System of Care. What we want to do over the next three years is use our funding to work with the staff about this fundamental relationship between staff and client that Ms. Kutik referred to, that has to do with enabling the client to self-direct, self-identify, and to self-manage their own mental illness in a way that is fundamentally good for them."

Ms. Brown: "Do you have job developers or a training program?"

Mr. Heasley: "One time we had a pretty robust training program but we closed it because we were losing money running small businesses that were serving a very narrow segment of people. Our clients wanted to do a wide range of things outside of the training we offered, and we found that we could use the same amount of money and work on looking for placements in real jobs with real time and managers and real training programs. We are very invested in job development, job placement, and retention in real jobs."

Dr. Turner: "Thank you so much."

2.2 Board discussion of Possible Board responses to the presentation

There was no Board discussion.

2.3 Public comment relevant to Item 3.0

Mr. Wise: "It seems like there is a glass ceiling for people in residential care. In particular with Conard House, why is it so difficult for people outside the Conard system? Do you have to start from the ground up or can one access independent apartments?"

Mr. Heasley: "We're working on that. Your glass ceiling analogy is exactly right."

Dr. Eve Myer, Executive Director of San Francisco Suicide Prevention: "I wanted to say to you how proud I was to see how Mr. Heasley and Ms. Kutik were received by all of you, and to thank you for giving them this warm reception."

3.00 ACTION ITEMS

3.1 Public comment relevant to Item 3.0

There was no public comment.

3.2 Resolutions.

3.2.a PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of November 8, 2006 be approved as submitted.

Minutes approved unanimously.

3.2.b PROPOSED RESOLUTION: Be it resolved that the notes of the Mental Health Board Retreat of December 9, 2006 be approved as submitted.

Notes approved unanimously.

3.2.c PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of January 10, 2006 be approved as submitted.

Minutes approved unanimously.

3.2.d PROPOSED RESOLUTION: Responding to Critical Foster Care Issues and Concerns. (Attachment A)

WHEREAS, 2,200 San Francisco children are in foster care, and

WHEREAS, 70% of the children in foster care are African American, while only 8% of the City's population is African American, and

WHEREAS, too many children in foster care end up in the criminal justice system, and

WHEREAS, 24% of the San Francisco murder victims were previously in foster care, and
WHEREAS, 39% of the suspects committing the murders in San Francisco were in foster care, and

WHEREAS, the substance abuse rate is higher for foster care children, and

WHEREAS, the suicide rate is significantly higher for foster care children, and

WHEREAS, many Grandparents are assuming responsibility for caring for their grandchildren, and

WHEREAS, the potential for child abuse is higher in foster care, and

WHEREAS, 55% of foster care children receive mental health services, and

WHEREAS, children are being released out of the foster care system without needed support, knowledge, and vocational skills to succeed, and

WHEREAS, mental health care for children in foster care when they are young will save tax dollars in the future.

BE IT RESOLVED that financial support and mental health services for grandparents taking care of grandchildren needs to be available, and

BE IT FURTHER RESOLVED that transitional care for youth 18 and older who age out of the system such as: job training, housing, school vouchers, financial aid, transportation (MUNI passes), and family planning needs to be available, and

BE IT FURTHER RESOLVED that the trend of case load reduction for child welfare workers be continued so that appropriate oversight is possible, and

BE IT FURTHER RESOLVED that all children entering the Foster Care System need a mental health assessment and counseling made available.

Resolution passed unanimously.

3.2.e PROPOSED RESOLUTION: Be it resolved that the Mental Health Board commends Carmen Lee and Stamp Out Stigma. (Attachment B)

WHEREAS, Stamp Out Stigma, founded by Carmen Lee, is a nonprofit organization that is dedicated to raising awareness of mental illness among the public, and

WHEREAS, Stamp Out Stigma, using panelists who suffer from mental illness, educates people about the experience of being mentally ill, and

WHEREAS, Stamp Out Stigma contributes to reducing the stigma associated with mental illness by showing the human side of mental illness, and

WHEREAS, Stamp Out Stigma has given nearly 1,000 presentations to diverse audiences over the past ten years, and

WHEREAS, Carmen Lee, its founder has won many awards including a Lifetime Achievement Award from the Voice Awards, and

WHEREAS, Stamp Out Stigma contributes to educating the public in the hope that it will lead to greater compassion and understanding by all.

THEREFORE, BE IT RESOLVED, that the Mental Health Board of San Francisco commends and thanks the Carmen Lee and Stamp Out Stigma for their years of dedication and commitment to educating the public about mental illness.

Resolution passed unanimously.

3.2.f PROPOSED RESOLUTION: Be it resolved that the Mental Health Board commends Behavioral Health Court. (Attachment C)

WHEREAS, far too many people with mental illness end up in the criminal justice system rather than in the mental health system, and

WHEREAS, these people with mental illness need treatment rather than punishment, and

WHEREAS, the Behavioral Health Court is proving itself to be a very effective and humane way to help mentally ill offenders get into treatment, and

WHEREAS, the Behavioral Health Court involves a multidisciplinary team and is an excellent role model for the coordination and integration of services across City departments, and

WHEREAS, the Behavioral Health Court helps keep clients from falling into the cycle of recidivism, and

BE IT RESOLVED, that the San Francisco Mental Health Board commends the City and County of San Francisco for creating and supporting the Behavioral Health Court, and

BE IT FURTHER RESOLVED, that the Mental Health Board commends the Superior Court of the City and County of San Francisco, and especially Judge Mary Morgan and her colleagues for their strong commitment to the Court and their compassion for the clients of the Court, and

BE IT FURTHER RESOLVED, that the Mental Health Board urges the City and County of San Francisco to make it a priority to increase funding and support for the Court, so the Court can increase the number of clients it works with.

Resolution passed unanimously

3.2.g PROPOSED RESOLUTION: Be it resolved that the Bylaws of the Mental Health Board be changed as attached. (Attachment D)

ARTICLE III - MEMBERSHIP

The membership of the MHB shall at all times be as provided for in California Welfare and Institutions Code Sections 5604 et. seq., and San Francisco Administrative Code Sections 15.3 et. seq. This legislation includes a provision that a member shall be removed from office if he or she is absent from four meetings in one year. A leave of absence may be granted for up to ~~two~~ four months with prior approval of the Executive Committee. *In the case of medical illness, family emergency or other exigency, the Executive Committee may retroactively grant leaves as necessary.* If it is determined that a member has been absent from four meetings within a 12 month period, and no leave of absence has been granted, the MHB shall notify the Board of Supervisors in writing. Upon receipt of this notification, the position shall be declared vacant by the Board of Supervisors.

Resolution passed unanimously.

4.0 MENTAL HEALTH BOARD PRIORITIES FOR 2007

4.1 Public Comment Relevant to Item 4.0

There was no public comment.

4.2 PROPOSED RESOLUTION

RESOLUTION (MHB-2007-xx) Be it resolved that the following priorities be adopted by the Board for 2007 (Attachment E):

1. Develop new partnerships with other organizations in order to collaborate on mental health issues.

2. Lead and participate in education and advocacy efforts in identified legislative areas.
3. Provide education to San Francisco organizations and the community about critical mental health issues.

Resolution passed unanimously.

5.0 REPORTS

5.1 Report from the Executive Director of the Mental Health Board:

Ms. Brooke: "I want to welcome LaVaughn Kellum King back to the Board. She's been re-appointed by Supervisor Alioto-Pier. We are very glad to have her back.

Thank you for signing the cards for Ms. Walker and Mr. Douglas.

Finally, for the March meeting, we are asking all of you to come at 6:00 p.m. so that we can have a SFMHEF, Inc. meeting. We have some important matters to attend to and I really will need people to be here at 6:00 p.m."

5.2 Report of the Chair of the Board and the Executive Committee:

Dr. Turner: "We have Ed Jew committed for March. We are trying to get Toni Heineman for March as well. She does in-home counseling for foster care children."

5.3 Program's Committee Report: Rebecca Turner, Ph.D.

No report.

5.3a Planning Committee Report: Tom Purvis

Mr. Purvis: "Mr. McGhee would you like to speak first?"

Mr. McGhee: "I'd like to say that the Planning Committee has been working really hard. We've been meeting regularly, and Mr. Purvis, even though he had surgery, has been very committed and dedicated in this effort, and I wanted to publicly acknowledge him for this.

I contacted Assemblyman Mervyn Dymally of the 57th District. Assemblyman Dymally is one of the senior members of the State Assembly. He was also Lieutenant Governor. He currently chairs the Health Committee for the State. We have asked him be our keynote speaker for May 31st which is our chosen date. That date is free for Mr. Dymally as of today, and I hope he will accept our invitation. I will be following up on this the first part of next week. The quicker we can confirm him, the sooner we can begin promoting the event.

James Keys is working very hard on finding us a venue. He is very close to achieving this, and I want to thank Mr. Keys for taking the lead on this.

I also want to say to the Board that Ms. Brooke has been working very closely with the Committee. Her experience has added value to our process."

Mr. Purvis: "I will just briefly summarize where we are in terms of the categories.

At first we were looking very broadly at awarding any kind of business in San Francisco that would be a good employer. That obviously turned out to be too broad and too much work for this year; so at our last two meetings, we narrowed the categories down and made them much more relevant to the work of this Board.

We are looking at four categories:

- Criminal Justice Response to Mental Illness

We will recognize the work of the San Francisco Police Department for their participation in the Crisis Intervention training that many of us have been a part of. Sgt. Michael Sullivan and Officer Kelly Dunn have been very supportive with this training program.

- Foster Care and Mental Illness

We want to recognize programs that are responding effectively to mental health issues that foster care children are struggling with. In particular, acknowledging the work of the Disproportionality Task Force who have presented to us, Family Mosaic, and Home Within.

- CHBS Contract Programs

We will be looking at programs that are doing an effective job promoting a healthy workplace. These programs will be categorized as small, medium, and large organizations. For this category, we have criteria, which we will be refining at the Executive Committee meeting tomorrow night.

- Violence Prevention

We're looking at awards for programs and individuals who are both inside CBHS, and outside who are doing positive work to prevent violence.

I think what we have now done is narrow the scope of the program down to something feasible. It we get Assemblyman Mervyn Dymally, that will be a real coup. He has been around for decades and is a very, very effective legislator. This would put us on the map if we can get him to come.

We will have a more detailed report with a lot of these issues worked out by the next meeting, but this is where things stand for now. We are open to any suggestions any of you may have for more categories or agencies you would like to see recognized."

Mr. McGhee: "If for some reason we can't get Assemblyman Dymally, I'm going to ask California State Senator Mark Ridley-Thomas. He is the chair of the powerful Business, Profession, and Economic Development Committee, but more than that, he is also the chair of the Health Committee for the State. I often meet him in Sacramento."

Dr. Moses: "Have you looked at local presenters for cost effectiveness?"

Dr. McGhee: "I don't see this being an issue."

Dr. Moses: "That's not my question. Do we have a budget to pay speakers?"

Mr. Purvis: "We are looking at funding from different sources. We are looking at holding the event at the ARC or the Museum of the African Diaspora. James Keys is looking into this."

Dr. Turner: "We don't have a budget item for this event."

Mr. McGhee: "I'm in the process of trying to raise \$2000.00, and Ms. Brooke knows of a source that provides \$2000.00 grants."

Ms. Brooke: "I'm meeting with Janssen tomorrow. They have \$2000.00 grants for events like this."

Mr. McGhee: "We do need to develop a budget. We are looking at \$4000.00. We are also looking at ways of cutting this cost. Previously we talked about the possibility of approaching some restaurants to provide catering in exchange for promoting them."

Dr. Turner: "Congratulations to this committee for coming so far in the process. Mark your calendars for May 31st."

Ms. Brooke: "We are looking at Belva Davis and Caroline Tyler as possible MCs for the event."

Dr. Turner: "We are hoping to get the Mayor involved."

5.4 Budget Committee Report: James McGhee

No report.

5.5 Report by members of the Board on their activities on behalf of the Board.

Dr. Moses: "What about the registration for the Mental Health Boards/Commissions Regional Training the weekend of April 6th?"

Ms. Brooke: "Registration and lodging are free. We can cover transportation costs if needed. I encourage you all to attend."

Mr. Purvis: "Kitty Dukakis, wife of former Massachusetts Governor and presidential candidate, Michael Dukakis, is speaking next week at our NAMI meeting. That's Tuesday, February 21st at 1010 Gough St."

Mr. Keys: "Supervisor Daly's office is working on a draft that will come from the Board of Supervisors opposing the Governor's attempt to cut AB 2034 funds. We hope that people will support it."

Mr. Casados: "I belong to another board, the Vocational Task Force. We put together a fund allocation list of agencies that are getting MHSA funds. You can compare it to the CBHS list."

5.6 New Business

There was no new business

6.0 PUBLIC COMMENT

Mr. Kalman: "I would like to talk about Attachment D related to the California Welfare and Institutions Code. I happened to read this code at the law library today, and based on what I understand, your resolution isn't necessary. What is proposed in your resolution is already covered in the language of the Code. I think your resolution is not necessary and gives the bureaucracy lots of problems."

ADJOURNMENT:

There being no further business, the meeting was adjourned at 9:00 p.m.

SAN FRANCISCO MENTAL HEALTH BOARD



Gavin Newsom
Mayor

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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, March 14, 2007

City Hall

One Carlton B. Goodlett Place

2nd Floor, Room 278

6:30 p.m.

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CALL TO ORDER

ROLL CALL

AGENDA CHANGES

Item 1.0 DISCUSSION WITH SUPERVISOR ED JEW, DISTRICT 4

- 1.1 Public comment relevant to Item 1.0

Item 2.0 DIRECTORS REPORT

For discussion.

- 2.1 Discussion regarding Community Behavioral Health Services Department Report, a report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.

- 2.2 Public comment relevant to Item 2.0

Item 3.0 PRESENTATION: Counseling for Foster Care Children, Toni Heineman, PhD, A Home Within

For discussion.

- 3.1 Presentation: Counseling for Foster Care Children
- 3.2 Board discussion of possible Board responses to the presentation.
- 3.3 Board discussion of future presentations and agenda items.

3.4 Public comment relevant to Item 3.0

Item 4.0 ACTION ITEMS

For discussion and action.

4.1 Public comment relevant to Item 4.0

4.2 Proposed Resolutions

4.2.a PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of February 14, 2007 be approved as submitted.

Item 5.0 REPORTS

For discussion and possible action.

5.1 Report from the Executive Director of the Mental Health Board.

5.2 Report of the Chair of the Board and the Executive Committee.

5.3 Planning Committee Task Force Report: Tom Purvis

5.4 Report by members of the Board on their activities on behalf of the Board.

5.5 New business - Suggestions for future agenda items to be referred to the Executive Committee.

5.6 Public comment relevant to Item 5.0

Item 6.0 PUBLIC COMMENT

Members of the public may address the Mental Health Board on any items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board.

ADJOURNMENT

DISABILITY ACCESS

1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Edwin Batongbacal at (415) 255-3446 (voice) or (415) 255-3449 (TTD). Five days notice before the meeting will help to ensure the presence of an ASL interpreter or sound enhancement system. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.

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The ringing of and use of cell phones, pagers, and similar sound-producing electronic devices are prohibited at this meeting. Please be advised that the Chair may order the removal from the meeting room of any person(s) responsible for the ringing or use of a cell phone, pager, or other similar sound-producing electronic devices.

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Sunshine Ordinance Task Force
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To view Mental Health Board agendas and minutes, you may visit the MHB web page at: www.sfgov.org/mental_health. You may also go to the Government Information Center at the Main Library at Larkin and Grove in the Civic Center. You may also get copies of these documents through the MHB office at 255-3474.

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SAN FRANCISCO MENTAL HEALTH BOARD

Gavin Newsom
Mayor

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UNADOPTED MINUTES

Mental health Board

Wednesday, March 14, 2007

City Hall, Room 278

San Francisco, CA 94102

DOCUMENTS DEPT.

APR - 5 2007

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PUBLIC LIBRARY

BOARD MEMBERS PRESENT: Rebecca Turner, Ph.D. (Chair) (by phone); James L. McGhee (Vice-Chair); James Shaye Keys (Secretary); Bridgett Brown; Benito Mr. Casados; LaVaughn Kellum King; Claudia Lebish; Toye Dr. Moses, Ph.D., M.P.H.; Tom Purvis; Jagruti Shukla, M.D., M.P.H.; Lisa Williams.

BOARD MEMBERS ABSENT: Bob Douglas, Esq; Jeanna Eichenbaum, L.C.S.W.; John Kevin Hines; Kate Walker; Virginia Wright.

OTHERS PRESENT: Helynna Brooke (MHB Executive Director); Ayana Baltrip-Balagas (MHB Administrator); Emeric Kalman, Member of the Public.

CALL TO ORDER

The meeting was called to order at 6:35 p.m. by James L. McGhee (Vice-Chair).

ROLL CALL

Ms. Brooke read the roll.

Item 1.0 DISCUSSION WITH SUPERVISOR ED JEW, DISTRICT 4

Mr. McGhee: "Supervisor Jew is here to speak with us tonight. He represents District 4 in the Sunset. He is a third generation San Franciscan, and the Canton Flower shop opened by his grandparents in Chinatown is still thriving today."

Supervisor Jew: "Thank you for having me here tonight. There are new immigrants coming to San Francisco who have mental health issues, and we need to provide them services. We are hoping to set up three to four services in the Sunset and are looking for assistance with funding and finding locations to provide them. Perhaps this board could help us with this."

Mr. Keys: "Thank you for being here tonight Supervisor Jew. There is Proposition 63 funding that can go to community-based organizations in your area. We are looking for support from the Board of Supervisors in making sure funding is not cut from AB 2034."

Second, I believe that there is a need for creative and supportive outlets for youth in your district."

Supervisor Jew: "I spoke with several judges who are concerned about youth violence. We have a number of young adults and teenagers who have difficulty in expressing themselves, and when they have that problem, the last resort is violence; and this is something we need to address. If we can do this at an earlier stage, we won't have these issues that arise at later in the youth's lives."

I appreciate your comment and I look forward to working with this board to find a solution for these individuals who are having problems communicating with their parents or in school. We need to address these problems early on."

Mr. Casados: "We're looking for a supervisor to sit on our board. Maybe you would be interested in joining us."

Supervisor Jew: "I'll look into this. If I cannot make it, can I send an aide? I also wanted to mention that I am working closely with Lincoln High School and the San Francisco Unified School District on how we can develop bylaws to help address the issues regarding care for our youth and seniors."

Dr. Moses: "Language barrier is a big problem. It would be good to look for Federal funding to address some of the issues you mentioned tonight. I would also like to see continued funding for substance abuse needs."

Supervisor Jew: "We need to look more broadly at this issue of language and immigrants. I don't mean just Asian. We have immigrants coming from many places and we must take a broader look at this issue. We want everyone to be able to adjust and be an asset to society."

Dr. Shukla: "Shame around mental illness is an important issue with immigrants, particularly Asians. We need to create ties with local groups and develop a network within the communities to help immigrants who are struggling with the issue of stigmatization."

Supervisor Jew: "I agree with you that there are individuals, not necessarily in my district, but in Chinatown who feel uncomfortable to speak about the issues confronting them. We need to address this problem with Public Service Announcements (PSAs), informational mailers, print ads, and buy free advertisements with newspapers. We need not to neglect these individuals, because when we do, we send a negative message that it's okay to mistreat people with mental illness. We need to educate everybody on a mass level. I have a good rapport with the ethnic newspapers. We can also approach the ethnic television and radio stations."

Mr. Keys: "You are on the right track with the idea of using PSAs and other types of promotions to help de-stigmatize mental health issues within certain communities. I'm sure the department of mental health would be able to help. I would like to challenge you to look outside of the usual avenues. Turning a simple pizza party into an educational party about the use of medications, or where people can go for confidential health services could be a unique promotional strategy. I encourage you to think outside of the box."

Ms. Kellum King: "You could approach the National Association for the Mentally Ill (NAMI) as well. A 12-week workshop is coming up in September for family members. When you have the tools to work with mental illness, progress can be made."

Mr. Purvis: "I was also going to mention NAMI. In addition to Family-to-Family, we have monthly meetings. We had more than 100 people at our last meeting. This was very exciting. There are also small support groups and we are trying to reach out to the Asian communities."

Supervisor Jew: "I'm really excited with the idea of using PSAs. I can talk with the press on how we can really start educating the public. We need to address the problems people face early on."

I want to thank for having me."

Mr. McGhee: "On behalf of the Board, thank you Supervisor Jew for taking time to come address us tonight."

1.1 Public comment relevant to Item 1.0

There was no public comment.

Item 2.0 DIRECTORS REPORT

Dr. Cleghorn: "Good Evening and thank you for having me back."

Dr. Cleghorn presented the Director's Report:

Monthly Director's Report

March 14, 2007

1. **8-week Workshop on Coping with Depression.** A free training open to consumers who are part of the CBHS Peer Intern Program, or consumers working at CBHS programs, will be held Thursday evenings from March 15 to May 3, from 5:00 - 7:00 PM, in the SOMA/Civic Center area. The training consists of a series of weekly classes focusing on a mindfulness-based approach towards investigating and working with depression. The classes will also cover basic education about depression, and take home exercises that emphasize the links between thinking, feeling, body sensation and depression. For more information and to register for this training, please visit the webpage at <http://www.mha-sf.org/library/copingwithdepression2007.pdf> Please register ASAP as this class will fill up fast! (For those of you who are not are part of the CBHS Peer Intern Program or are consumers working at CBHS programs, we plan to offer this training again to the public sometime this year. Please stay tuned for details.)

2. **National Registry of Evidence-based Programs and Practices (NREPP).** The Substance Abuse and Mental Health Services Administration (SAMHSA) has launched a searchable database of evidence-based practices in prevention and treatment of Mental Health and Substance Use Disorders. The new National Registry of Evidence-based Programs and Practices (NREPP) is available on the web at <http://www.nrepp.samhsa.gov>

NREPP is a searchable database with up-to-date, reliable information on the scientific basis and practicality of interventions. Users, such as community organizations and state and local officials can perform custom searches to identify specific interventions.

Key features of the new NREPP system include:

- Custom searches based upon desired outcomes, target populations and service settings;
- Details on each intervention including: a brief descriptive summary, the type of outcomes achieved, the costs of implementing the intervention, and the complete contact information for the intervention developer;
- Two independent expert ratings for each intervention – the first assessing the quality of research supporting specific intervention outcomes, and the second assessing the availability of implementation and training materials to support adoption of the intervention in routine service settings.

3. **CBHS Integration.**

Zialogic will be arriving for its **Quarterly consultation on April 13, 2007**. They will meet with the Integration Advisory Committee at 10-11:30am at 1380 Howard Street, 4th Floor Conference Room and then with Change Agents in the afternoon beginning at 1:00pm at the Ba'hai Center, 170 Valencia Street/ Duboce.

The Integration Advisory Committee is working on Integration Activities for FY 07-08, and the Change Agents will focus on use of the CODECAT and the ILSA. The CBHS Integration Implementation Workgroup (IIW) is pleased to announce the appointment of 3 Co-chairs: Albert M. Eng, Ernestina Carrillo and Deborah Sherwood. The IIW focuses on performing the “hands on” work necessary to implement integration at CBHS. Our thanks to the co-chairs for volunteering for this role!

4. **Mental Health Service Act Update.**
COMMUNITY SERVICES AND SUPPORTS

MHSA – FSP SERVICES:

100 partners have been authorized to receive full service partnership services as of February 2007. The table below shows the age group of these partners and agencies where they were referred to:

MHSA FSP Client Authorizations Fiscal Year 2006 - 2007											
AGENCY	UDC	AgeGroup	Nov-06	Dec-06	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Total
Family Service Agency	27	Adult	1		3	8	7				19
Hyde Street Community Center	27	Adult	7		3	4	3				17
UCSF Citywide Case Management	27	Adult		2	1	9	1				13
Family Mosaic Project	27	CYF									-
Seneca	27	CYF		18	4	6					28
Family Service Agency	34	OA				6	3				9
CBHS-TAY	17	TAY									-
Family Service Agency	17	TAY			6	5	3				14
Total	203		8	20	17	38	17	-	-	-	100

MHSA – HSP SERVICES:

Of the twenty-two (22) stabilization units available for FSPs, seventeen (17) are occupied through February 2007. Two partners are currently applying for permanent housing units. Four TAY partners are in permanent housing.

MHSA – SYSTEM DEVELOPMENT:

As of the end of December 2006, a total of 204 clients were served by various agencies – 117 CYF, 14 – TAY, and 73 – Adults.

WORKFORCE EDUCATION AND TRAINING:

The draft plan has been posted on the MHSA website at <http://www.dmh.ca.gov/mhsa/EducTrain.asp>. The public comment will end on Monday, March 19, 2007. Community Behavioral Health Services will initiate the planning process as soon as the final guidelines are released. If you would like to participate, please contact our Director of Training and co-chair of this planning committee, Toni Rucker, at the contact information provided below. Attached is a summary of the key guidelines for developing a county plan.

MHSA HOUSING PROGRAM:

The MHSA Housing Program will now be consolidated with the Community Services and Supports. This change was made in recognition that housing is an integral element to the wellness and recovery of individuals with severe mental illness. \$75 million will be distributed to the counties to finance the capital costs associated with development, acquisition, construction and/or rehabilitation of permanent housing and \$40 million for operating subsidies. The draft of the local plan requirements is expected to be released in April 2007.

PEER AND STAFF TRAINING SCHEDULES

March

Coping with Depression - The Mental Health Association of San Francisco will hold an 8 week workshop on Coping with Depression every Thursday from March 15 – May 3, 2007 from 5:00 pm – 7:00 pm in the SOMA/Civic Center area. This **free** training is open to mental health consumers who are part of the Community Behavioral Health Services (CBHS) Peer Intern program or mental health consumers *working* at CBHS programs or CBHS-funded non-profit contractor agencies. For more information and to register for this training, please click here: <http://www.mha-sf.org/library/copingwithdepression2007.pdf>. Please register ASAP as this class will fill up *fast*!

Clinical Supervision: Integration Implementation and the Changing Environment – Dr. David Mee Lee will conduct this training on March 19, 2007. This training will discuss the stress of integration and the changing environment, the kinds of supervision needed, different learning styles, and individualized staff supervision.

MHSA Advisory Community Meeting

The Mental Health Services Act Advisory Committee meets bi-monthly from 3-5pm, alternating between advisory meetings and community forums. The next meeting will be a community forum in the Mission district on **April 25, 2007** at **Friendship House, 56 Julian Avenue**.

5. Comings and Goings.

Please welcome two new valuable additions to the BHIS Team.

Steve Solnit, IS Business Analyst for our MHSA and FSP implementation. Steve has several years experience with SQL, MS Access and Health Information Technology as well as public health experience.

Jim Brehmer, Sr IS Business Analyst for new systems implementation and systems support. Jim has several years experience in DPH and extensive experience maintaining servers and applications.

We would also like to extend a warm welcome to our new *MHSA Implementation Specialists* to our CBHS employee roster. Those new employees are Edward Alvarez, Gwendelyn Brinkley, Stephen Maher, Nathaniel Mitchell, Deborah Williams, and Michael Wise. They come from a wealth of backgrounds in positions that deal with mental health issues. They will be located on the second floor of 1380 Howard Street and they will work varying schedules. Please pass by and give them a warm welcome.

6. Awards.

Congratulations to one of our own, Master Sergeant Steve R. Sigman, Steve who works as IT Support Services Supervisor at 1380 Howard, was presented a State Of California Acknowledgment Plaque from Air Force Command Chief Master Sgt. Henry Fernandez, who is the Senior Enlisted Advisor to the Adjutant General of the California National Guard and the Commander of California. Governor Schwarzenegger presented Steve with an Excellence Award for his continued service of 30 years of which 10 years were in the position of First Sergeant of the 129th Medical Group at the 129th rescue Wing. During the ceremony it was acknowledged that Steve has achieved the record for the longest held first sergeant position, which is normally held for 3 years. Command Chief Fernandez who is currently in his 7th year, stated that Steve has held this position longer than he. Steve has had the opportunity to serve abroad and here at home such as Hurricane Katrina relief, where he served as the first Sergeant for the EMEDDS, 149 doctors and nurses, he cared and provided services to over 3,400 patients during his tour.

Congratulations to Master Sergeant Steve R. Sigman!



7. Other Upcoming Events:

Tools Needed for Clinical Supervision - David Mee-Lee, MD, **March 19th**, Friendship House, 56 Julian Avenue. This workshop will highlight the importance of supervision to help counselors, clinicians, clinical managers, supervisors and administrators deal with the changes necessary personally, professionally and programmatically

STAR*D: Answers, Surprises, Disappointments – J Craig Nelson, M.D. **March 20th**, Fort Mason, Room 260. This presentation will review the design and methods of the STAR-D study and present the primary findings. Problems encountered will be reviewed as well as surprising findings.

Disaster Mental Health, Critical Stress Management: Basic Group Crisis Intervention Part II – Diane Myers, **April 26-27, 2007**, 450 Golden Gate Avenue, Arizona Room. **PREREQUISITE: NEED TO TAKE SESSION 1, ESSENTIALS OF DISASTER MENTAL HEALTH ON 4/19 & 4/20 OR KEY CONCEPTS OF DISASTER MENTAL HEALTH HELD IN PREVIOUS YEARS**

To register for these trainings, please contact Norman Aleman, CBHS Training Coordinator at 415-255-3553 or email norman.aleman@sfdph.org

Past issues of the CBHS Monthly Director's Report are available at: <http://www.dph.sf.ca.us/CBHS/default.htm> To receive this Monthly Report via e-mail, please e-mail kathleen.minioza@sfdph.org

Dr. Cleghorn: "As Ms. Brooke mentioned, I'm in charge of integration at Community Behavioral Health Services (CBHS) and I recently did an update to the Health Commission on our progress, and I would be happy to come back at another time to update the Board on the programs and our progress with integration.

We've done a lot of work this year. One of the things we've done is revamp our working body at CBHS with the Integration and Implementation Work Group. I have three co-chairs that are now running that group—Dr. Albert Eng who is with Children Services, Ernestina Carrillo who is with Adult Services, and Deborah Sherwood who is Director of Research and Evaluation.

In regard to the Mental Health Services Act (MHSA), there are some official challenges to the Governor's proposal to cut AB 2034 funds, but people need to follow up on this as much as possible because we are not out of the woods yet.

I have updates on our programs that we implemented with our MHSA funds. The first of these is the Full-Service Partnerships. You can see the data in the chart in the full Director's Report. The majority of these programs are up and running with the exception of the Family Mosaic Project and the CBHS Transitional Age Youth Project.

The target population for these programs consists of people who've never been served by our system or those who are finding difficulty getting adequate care. There are different age group targets. We have funded three adult Full-Service Partnerships, and two Children, Youth and Family Partnerships, one Older Adult Partnership, and two Transitional Youth Partnerships and to date, we've authorized 100 individuals for enrollment in services, and we expect to have all programs enrolled by the end of the fiscal year in July. Everyone is making good progress.

Accompanying the Full-Service Partnerships, we have arranged a 2-tier housing program. The first aspect of the housing that will come into place will be the stabilization housing units, and the second aspect will be permanent housing units.

We started with the stabilization units because the application process for permanent housing can sometimes take months, and we wanted to place people first in the stabilization units so that we can then have the time to help them work through the process of getting permanent housing. We have 17 of the stabilization housing units currently occupied, and we have four people in the process of applying for permanent housing."

2.1 Director's Report: Board Discussion

Mr. Keys: "With the permanent housing, will people have to worry about not having to use their full check to cover the housing costs?"

Dr. Cleghorn: "We are working with our Department of Housing and Urban Health, to set up and work through the details. Tenants will have to make a contribution, but the Department is aware of the issues they face."

Mr. Keys: "I received a call from a person who is paying 98% of their Social Security check on rent alone leaving virtually nothing to live on. Is there something being developed that is going to help these people, like a housing fund to help them subsidize their rent?"

Dr. Cleghorn: "Hopefully we will be able to apply for funds from the \$75 million set aside by the Governor for housing. The guidelines are posted on the Department of Mental Health website under 'Housing'.

Training is gaining momentum. We have limited funds for this. The planning process needs to happen with Community Health. We expect the funding to be significantly less than \$1,000,000 this year."

Dr. Turner: "I understand that a Request for Proposal (RFP) has already been released for Training and Education. People have contacted me concerning this."

Dr. Cleghorn: "That is not correct. There is a draft plan from the State on the Mental Health Association's website. Public comment on this draft plan ends March 19th. This is not an RFP. This could have been a source of some confusion. We have not put a plan together to apply for RFP services yet, and we are not allowed to apply to State yet."

Dr. Turner: "What is San Francisco's next step?"

Dr. Cleghorn: "We hope to begin a planning process in April. We hope we will have all the information in terms of the funding needed for us to begin the RFP process in April, May, and June. We need to post the plan for public comment so that we can get it in on time at the State level. Gina Redmond who is with San Francisco State University will co-chair this committee with Toni Rucker who directs training at CBHS."

Dr. Turner: "I think the Mental Health Board needs to gear up to begin to hold public hearings."

Dr. Cleghorn: "The State doesn't require public hearings. Our strategy was to get the plan in a form that could be passed out at one of the Mental Health Advisory Committee meetings; have it as part of the Director's Report to the Mental Health Board, and also have it widely distributed through some of our other avenues like the Mental Health Association."

Dr. Turner: Is the MHSA Advisory Board that Benito is on involved in the planning process?"

Dr. Cleghorn: Yes. The next MHSA Advisory Committee meeting is from 3:00pm-5:00pm on April 25th at Friendship House.

We have hired five new *MHSA Implementation Specialists* to our CBHS employee roster—Edward Alvarez, Gwendelyn Brinkley, Stephen Maher, Nathaniel Mitchell, Deborah Williams, and Michael Wise. All but Nathaniel began work on Monday. Nathaniel will be starting soon. We are very pleased to have them, and value the diverse backgrounds and experience they are bringing to CBHS, in helping us improve our communication with the communities.

Finally, we have another excellent training on March 19th — *Tools Needed for Clinical Supervision* given by Dr. David Mee-Lee. This workshop will cover the importance of supervision to help counselors, clinicians, clinical managers, supervisors and administrators deal with the changes necessary, personally, professionally and programmatically. This will also be presented at Friendship House, and is related to our integration efforts at CBHS."

Mr. Casados: "How many stabilization rooms are going to be brought online in total? How are people going to be moved from stabilization rooms to permanent housing?"

Dr. Cleghorn: "Full-Service Partnerships will help this process. Our ultimate goal is to move everyone into permanent housing. We have increased the stabilization units from 11 to 22. There are 20 permanent units available. We are hoping to obtain additional permanent housing in the next fiscal year."

Mr. Keys: "There is a great need for more on-sight counseling. Many of these people need some type of training to develop life skills before moving into a building. Does mental health have a program to work with property owners to get a block of rooms for people with issues to aid them in getting acclimated to a more stable life?"

Dr. Cleghorn: "Some of the upcoming housing funds could be set aside for this type of training; but currently, we have housing support services funded at three agencies—Curry Senior Center for older adults, Larkin Street for transitional-age youth, and Central City Hospitality House for adults. These funds are used to help those who are homeless or close to becoming homeless. Case management services are supported as well as money-management training, any kind of service the client may need."

Dr. Moses: "In Item No. 5 you mention five or six new hires. What is their ethnic and gender breakdown?"

Dr. Cleghorn: "One Latino, three African-Americans, two white, two women, three men."

2.2 Public comment relevant to Item 2.0

Ms. Maas: "I heard there may be a group that is working to address the mental health disparities with agencies who did not receive funding from the first rollout."

Dr. Cleghorn: "We don't have anything like that. It's up to the new hires to work on community contact. The Stigma campaign falls under prevention and early intervention funds. There will be one of the new hires who will be working with youth."

Mr. Kalman: "Can we have for the future, something that is clearer to read for the lay people?"

Is there any survey on the homeless needs? How many homeless have mental health needs? Is there a survey with this information?"

Dr. Cleghorn: "There was an extensive planning process which included many community forums on this topic during the initial planning of MHSA."

The Oversight Accountability Committee is meeting next Thursday and Friday to further look at these issues. The agenda is on the Department of Mental Health website."

Item 3.0 PRESENTATION: Counseling for Foster Care Children, Toni Heineman, PhD, *A Home Within*

3.1 Counseling for Children in Foster Care

Mr. McGhee: "I would like to welcome, Dr. Toni Heineman, founder and Executive Director of *A Home Within*, the only national organization focused exclusively on the emotional well being of foster youth. She is also a Clinical Professor at the University of California, San Francisco in Psychiatry and Pediatrics and the author of several articles on psychotherapy with children. She has made numerous presentations to lay and professional audiences about the mental health issues facing foster care children. Dr. Heineman authored *An Abused Child: Psychodynamic Understanding and Treatment* and co-edited *Building A Home Within: Meeting the Emotional Needs of Children and Youth in Foster Care*. She has been awarded a Leadership Fellowship with Zero to Three and a Draper Richards Social Entrepreneur Fellowship."

Dr. Heineman: "Thank you for inviting me. First I would like to give you an overview of our program and then I will be happy to answer your questions and discuss mental health issues faced by children in foster care and what we can do about them."

Dr. Heinemen gave an audiovisual presentation:

A Home Within: Building Continuous Connections for Foster Youth

The single most important factor influencing a positive outcome for foster children and youth is a lasting relationship with a caring adult.

- **The Trauma of Chronic Loss**

It is virtually impossible to overestimate the impact of chronic loss on development, particularly in the context of other traumatic events such as abuse, neglect, domestic or community violence.

- **Trauma**

A traumatic stressor is an event that threatens the psychological or physical integrity of the self or another person.

- **Complex Trauma**

Complex trauma refers to a child's exposure to multiple traumatic events occurring within the care-giving system. These initial traumatic experiences often lead to subsequent traumas.

Healthy development depends on stable, caring, and lasting relationships.

Repeated disruptions in the child's relationships with caregivers are traumatic and have a negative impact on development.

Early and dependable intervention can minimize the effects of traumatic loss.

- **Study of 85 cases active in San Francisco in 3/03**

Demographics matched that of foster care population

62% had a mental health referral form on file

Gender, ethnicity, reason for removal, and out-of-county placement were not associated with referrals

- **Factors Associated with Referrals**

Children entering the system after the age of five are more likely to be referred.

Children referred had an average of five placements and were referred after the third placement.

Breakdown of children referred for mental health intervention

The sample was relatively evenly divided between kids with 1-2 placements and 3 or more (up to 20)

Those referred earlier for mental health services had fewer placements in different homes.

- Successful Treatment

Establishes the capacity for affect regulation

Substitutes adaptive, self-caring behavior for mal-adaptive, self-injurious behavior patterns

Develops a coherent story that places traumatic events in perspective and integrates dissociated memories

Brings development into line with expectable norms

Creates the foundation for age-appropriate learning

Promotes a reliable self-concept and self-esteem

- Developmental Impact of Loss

Eight Ages of Man

Infants

Toddlers

Pre-school Children

Elementary School Children

Adolescents

Young Adults

Middle Aged Adults

Older Adults

- Chronic Loss and Insecure Attachment

Disorganized Caregiver and Caregiving system

- Infants

Trust vs. Mistrust

Impact of Chronic Loss

Emotional rigidity

Impairments in attention

Impairments in emotional, social, and cognitive domains

Disassociation

- Toddlers

Autonomy vs. Shame and Doubt

Impact of Chronic Loss

Difficulty in social functioning--sharing, playing, etc.

Poor impulse control

Sense of shame and humiliation

Disassociation

- Pre-schoolchildren

Initiative vs. Guilt

Impact of Chronic Loss

Constriction of play and initiative

Stress inhibits the development of integrative brain functions

Insecurely attached children may become overly compliant and/or excessively demanding of attention

Disassociation

- Elementary School Aged Children

Industry vs. Inferiority

Impact of Chronic Loss

Heightened stress interferes with attention and focus

Repeated moves disrupt educational process

Insecurely attached children begin acting out in order to demonstrate strength/power

Learning disabilities/disassociation

- Adolescents
Identity vs. Role Confusion

Impact of Chronic Loss

Difficult relationships with peers

Interpersonal violence

Difficulties in making commitments

Compromised sense of morality

Impaired sense of self and self esteem

Dangerous seeking of stimulation and tension discharge

- Young Adults
Intimacy vs. Isolation

Impact of Chronic Loss

Inability to form intimate relationships

Highly conflicted relationships

Depression

Violent and dangerous acting out

Compromised cognitive functioning

Disassociation

- Middle Aged Adults
Generativity vs. Stagnation

Impact of Chronic Loss

Feeling robbed of the chance to pass on knowledge and experience

Insecurely attached adults may either anxiously hover over children or activities or rigidly insist on premature independence

- Older Adults
Integrity vs. Despair

Impact of Chronic Loss

No sense of control over the events of one's life

No sense of connection to community -past, present, or future

Insecurely attached older adults are mired in their own helplessness and hopelessness

- Closing the circle of the life cycle

"Healthy children will not fear life if their elders have integrity enough not to fear death."

Dr. Heineman: "We started *A Home Within* in San Francisco in 1994, and I am thrilled and proud of the support we have had from the community. We have developed this model program on the national level as well, and it is growing across the country. We also have inquiries from Canada and Sydney, Australia to take the program there.

We are the only national organization focused exclusively on servicing mental health issues of children in foster care. There are local organizations that provide these services, and there are national organizations that have a component of their programs that addresses these issues. I'm very pleased to say we have one single focus.

We have an upcoming exhibit of our 'Fostering Art' program on Tuesday, April 24, 2007. At the end of every academic year this program has an exhibit of student work, and this one happens at the end of April to usher in National Foster Care Month, which is May.

All services are pro bono. We ask professionals in private practice to take one foster child into weekly psychotherapy and work with them until the therapy comes to a natural close. Just because a child turns 18, doesn't mean the therapy comes to an end. I want the foster children that come to us to get the same quality of services of those I would buy for my own children.

A Home Within is a collaboration between both the public and private sectors. We are dedicated to meeting all the needs of the charges we have. We offer professional care to the System of Care. It's an ongoing collaborative relationship.

I started the program because it was heartbreaking to see the children who had lost their family, their community, and their school. Children get shuffled around every six months, and what do they do, they shut down. I wanted to provide stability.

Chronic loss is an issue. One cannot overestimate the influence of this issue. I'm talking about repeated loss of caregivers.

What is a trauma? 'A traumatic stressor is an event that threatens the psychological or physical integrity of the self or another person.' Trauma for children is very different than trauma for adults.

Complex trauma: 'Complex trauma refers to a child's exposure to multiple traumatic events occurring within the care-giving system. These initial traumatic experiences often lead to subsequent traumas. 'The child's world is gone. An initial traumatic experience can trigger complex trauma in a child.

There is a term call 'toxic stress,' and it refers to ongoing levels of stress that have a negative impact on all aspects of a child's development.

We did a study at the request of Judge Donna Hitchens. We did random case studies of City programs for foster care to see if we could have better treatment referrals for mental health. What we discovered was that the average age of children entering foster care is five, the average age for referrals for mental health services is 11. By 11, a child has had three to four placements. Early referrals should help stabilize placements. Later referrals often result in multiple placements—up to 20.

Chronic Loss and Insecure Attachment:

A disorganized caregiver and system equals a disorganized attachment. Foster kids don't show up. They may disappear. Caregivers get lost along the way due to this disorganized structure. Disassociation is a constant in chronic loss situations.

Children develop mechanisms to sooth themselves. Trauma and stress interfere with the breakdown of the cohesive functioning of the brain."

Dr. Heineman reviewed the content of her Powerpoint found here in the minutes on pages 12-16.

3.2 Board Discussion of Possible Board Responses to the Presentation

Dr. Turner: "Any suggestions on ways to advocate for this population?"

Dr. Heineman: "We need more providers for these kids. I'm working with Sai Ling Chan-Sew and Alicia Lieberman on this issue to try to figure out ways to get more people in the private sector involved. We have to figure a way to make doing this work exciting to the private practitioners."

Dr. Turner: "Are there going to be any innovative proposals?"

Dr. Heineman: "We're developing a free training program for professionals who are actively seeing foster kids. They would receive Continuing Education Credits as an incentive to do this kind of work.

One of the other things we need to think about is attracting more minority professionals. We need more minority therapists and students in the university programs. We need to do outreach to undergraduate psychology and social work classes. No one is keeping foster care children in mind."

There is a very interesting statistic out of Denver. Every time a child has a new case worker, the chances for that child to have a permanent placement in the next 12 months decrease by 52%. That's alarming; and that's the case worker, not the foster care provider. Keeping the child in mind is extremely important."

Dr. Turner: "Early intervention is key and can make a huge impact. I would like to see if we could push through a resolution to the Board of Supervisors concerning this matter."

Dr. Heineman: "I just did a training on early intervention. There needs to be ongoing training. We're working on getting the word out. Every child needs a team working for her."

Dr. Moses: "Thank you for caring for so many children. Can you sponsor a program for peer counselors to provide counseling? How do you handle the issue of the revolving-door syndrome?"

Dr. Heineman: "We work with the coaches and other stakeholders, and we are committed to not being part of the revolving door. I think peer counseling is a good idea, but peers do not offer the same level of experience as therapists."

Dr. Shukla: "I'm impressed by the nature of your program, and your emphasis on longevity of care. Exposure to art supports the joy and pride in kids who are creating. How can we realistically match a child with a stable provider given the high change of jobs in the City?"

Dr. Heineman: "Expectation of completing the job when started is a good step."

3.3 Public Comment:

There was no public comment.

4.0 ACTION ITEMS

4.2 Proposed Resolutions

4.2.a PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of February 14, 2007 be approved as submitted.
Minutes passed unanimously.

5.0 ACTION ITEMS

5.1 Report from the Executive Director of the Mental Health Board

Ms. Brooke: "OMI has opened its new location. They are now located at 1701 Ocean Avenue.

I have a Police Crisis Intervention Training coming up April 9th through the 12th. If anyone wants to participate, please let me know.

HSN, the Human Services Network meets this Friday, the 16th. Their featured speaker is Controller Ed Harrington who will speak about the Joint Budget Report, which will be issued by the Controller, the Mayor's Budget Office, and the Board of Supervisors' Analyst.

KQED and Wells Fargo, with Gap, Inc. are celebrating Women's History Month on Wednesday, March 21, 2007. The program is *Honoring Local Heroes*, and will be held at KQED, 2601 Mariposa Street."

5.2 Report of the Chair of the Board and the Executive Committee

There was no report.

5.3 Planning Committee Task Force Report: Tom Purvis

Mr. Purvis: "We are still looking for a place for our May event. The Museum of the African Diaspora (MOAD) and Arc are potential places. We're going to try to settle this in the next week. We're working on pinning down the keynote speaker, and are looking at three people. We are still looking for funding avenues. Ms. Brooke is looking at Jansen, and Mr. McGhee is looking at other sources as well."

Mr. McGhee: "We are going to do a 'Save the Date' campaign which will go out the latter part of this month. We would like to reach at least 300 people. We are asking each board member to submit a list of 10 people to invite to Ms. Brooke. Our goal is to have 100 to 125 people at the event."

5.4 Report by Members of the Board on Their Activities on Behalf of the Board

There were no reports.

5.5 New Business

Mr. McGhee: "Benito is leaving us. He has been hired full time by the Family Services Agency as a case manager. This is a great opportunity, and we are extremely proud of him and wish him all the success on his new job."

5.5 Public Comment to Item 5.0

There was no public comment.

6.0 Public Comment

There was no public comment.

Adjournment

Meeting adjourned at 8:33 p.m.



SAN FRANCISCO MENTAL HEALTH BOARD

Gavin Newsom
Mayor

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
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www.sfgov.org/mental_health

MEETING OF THE MENTAL HEALTH BOARD

Wednesday, April 11, 2007
City Hall
One Carlton B. Goodlett Place
2nd Floor, Room 278
6:30 p.m.

CALL TO ORDER

ROLL CALL

10:30 a.m. mst

DOCUMENTS DEPT.

AGENDA CHANGES

APR - 5 2007

Item 1.0 DIRECTORS REPORT

For discussion.

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PUBLIC LIBRARY

1.1 Discussion regarding Community Behavioral Health Services Department Report, a report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.

1.2 Public comment relevant to Item 1.0

Item 2.0 PRESENTATION: SUPPORTIVE SERVICES FOR HOUSING: Sherilyn Adams, Larkin Street Youth Services; Jackie Jenks, Central City Hospitality House; Gay Kaplan, Curry Senior Center.

For discussion.

2.1 Presentation: Supportive Services for Housing

2.2 Board discussion of possible Board responses to the presentation.

2.3 Public comment relevant to Item 2.0

Item 3.0 ACTION ITEMS

For discussion and action.

3.1 Public comment relevant to Item 3.0

3.2 Proposed Resolutions

3.2.a PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of March 14, 2007 be approved as submitted.

Item 4.0 REPORTS

For discussion and possible action.

4.1 Report from the Executive Director of the Mental Health Board.

4.2 Report of the Chair of the Board and the Executive Committee.

4.3 Planning Committee Task Force Report: Tom Purvis

4.4 Report by members of the Board on their activities on behalf of the Board.

4.5 New business - Suggestions for future agenda items to be referred to the Executive Committee.

4.6 Public comment relevant to Item 4.0

Item 5.0 PUBLIC COMMENT

Members of the public may address the Mental Health Board on any items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board.

ADJOURNMENT

DISABILITY ACCESS

1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Edwin Batongbacal at (415) 255-3446 (voice) or (415) 255-3449 (TTD). Five days notice before the meeting will help to ensure the presence of an ASL interpreter or sound enhancement system. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.

2. Meetings are held at City Hall, One Dr. Carlton B. Goodlett Place (between Grove and McAllister), in Room 278. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro

station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and 71 Haight/Noriega. Also, the J, K, L, M, and N lines underground. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.

3. City Hall is accessible to wheelchairs. Elevators, doorways, restrooms, and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on One Dr. Carlton B. Goodlett Place.

4. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City accommodate these individuals.

POLICY ON CELL PHONE, PAGERS, AND ELECTRONIC DEVICES

The ringing of and use of cell phones, pagers, and similar sound-producing electronic devices are prohibited at this meeting. Please be advised that the Chair may order the removal from the meeting room of any person(s) responsible for the ringing or use of a cell phone, pager, or other similar sound-producing electronic devices.

KNOW YOUR RIGHTS UNDER THE SUNSHINE ORDINANCE

Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review. For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact:

Frank Darby
Sunshine Ordinance Task Force
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689
Telephone: (415)554-7724
Fax: 4(15) 554-5163
E-mail: sotf@sfgov.org

Citizens interested in obtaining a free copy of the Sunshine Ordinance can request one from Mr. Darby or by printing Chapter 67 of the San Francisco Administrative Code from the internet at: www.sfgov.org/sunshine.htm

To view Mental Health Board agendas and minutes, you may visit the MHB web page at: www.sfgov.org/mental_health. You may also go to the Government Information

Center at the Main Library at Larkin and Grove in the Civic Center. You may also get copies of these documents through the MHB office at 255-3474.

Lobbyist Registration and Reporting Requirements

Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance [SF Campaign & Governmental Conduct Code 2.100] to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; web site www.sfgov.org/ethics.

FREE SHOWING OF THE DOCUMENTARY “THE BRIDGE”

The **San Francisco Mental Health Board** and **Community Behavioral Health Services** are cosponsoring a free showing of the documentary movie, “*The Bridge*”.

Wednesday, May 16, 2007

6:30 – 9:00 PM

Dolby Laboratories

100 Potrero Avenue

San Francisco, CA



The film will be introduced by John Kevin Hines who is featured in the movie. Mr. Hines is the 26th survivor of a jump off the Golden Gate Bridge seven years ago. He will answer questions after the film is shown.

“The Bridge” is directed by Eric Steel and the documentary captures the people who attempted to jump off of the Golden Gate Bridge over the course of 2004. The Golden Gate Bridge is the site of more suicides than anywhere else in the world. Interviews with friends, family members, and eyewitnesses try to explain what led these people to end their lives this way. The interviews describe people struggling with mental illnesses such as severe depression, schizophrenia and bipolar disorders, and shows the anger and hurt of their loved ones.

The camera crew called authorities if they saw someone who might jump, but the documentary includes footage of moments leading up to and including the suicides, so discretion is advised for sensitive viewers.

Seating is limited to 80 persons. Please call 415-255-3473, or email hbrooke@mentalhealthboardsf.org to **reserve** your seat.



SAN FRANCISCO MENTAL HEALTH BOARD

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www.sfgov.org/mental_health

FOR IMMEDIATE RELEASE:

Friday, March 30, 2007

Contact: Mental Health Board Office

415-255-3474

San Francisco Mental Health Board launches new user friendly Website!

PRESS RELEASE

The San Francisco Mental Health Board is excited to announce its new user-friendly website. The address is: www.mentalhealthboardsf.org.

The site has information about the Mental Health Board and the work it is doing. There are answers to frequently asked questions about mental illness. Community support services are listed with descriptions and contact information. Many community resources are listed as well as links to information about mental illness on the internet.

The site is also linked to www.sfgov.org, the San Francisco government website. The Mental Health Board's agendas, minutes, and annual reports can be found at the official site at www.sfgov.org/mental_health.

The Mental Health Board welcomes your emails and comments about its website.



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SAVE THE DATE

San Francisco Mental Health Board Community Awards Reception

Thursday, May 31, 2007

6:00 to 8:00 PM

Venue information to follow

Mistress of Ceremonies: Belva Davis

Keynote Speaker: Assemblyman Mervyn Dymally,
Chair of the Health Committee for the California State Assembly

MENTAL HEALTH BOARD OF SAN FRANCISCO

HELP IMPROVE THE MENTAL HEALTH SYSTEM

The **Mental Health Board** is seeking applicants for a *Consumer* seat on the Board. You must be a current or former client of the public mental health system, a resident of San Francisco, a citizen of the United States, over 18 years of age, and you cannot work for Community Behavioral Health Services or one of its contractors.

As a Board member you would:

1. Attend the Board meeting on the second Wednesday evening of each month, from 6:30 to 8:30 p.m., at City Hall, One Carleton Goodlett Place, 2nd Floor, Room 278.
2. Serve on a committee of the Board and attend committee meetings one evening a month.
3. Participate in at least one program review each year.
4. Attend the Annual Retreat.

If you are interested in applying to the Board, please don't be shy about calling Helynna Brooke or Ayana Baltrip-Balagas at the Mental Health Board office—415/255-3474. They welcome your questions.

You don't have to have lots of policy experience to be a valuable member. What matters is that you care deeply about making sure that the best possible services get to everyone who needs them. New members get lots a support from our veteran members and our staff. And you get to know a lot of great people.



Gavin Newsom
Mayor

SAN FRANCISCO MENTAL HEALTH BOARD

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UNADOPTED MINUTES

Mental health Board

Wednesday, April 11, 2007

City Hall, Room 278

San Francisco, CA 94102

DOCUMENTS DEPT.

MAY - 4 2007

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BOARD MEMBERS PRESENT: James L. McGhee (Vice-Chair); James Shaye Keys (Secretary); Bridgett Brown; Jeanna Eichenbaum, L.C.S.W.; LaVaughn Kellum King; Claudia Lebish; Toye Moses, Ph.D., M.P.H.; Tom Purvis; Jagruti Shukla, M.D., M.P.H.; Kate Walker; Lisa Williams; Virginia Wright.

BOARD MEMBERS ABSENT: Rebecca Turner, Ph.D. (Chair); John Kevin Hines;

OTHERS PRESENT: Helynna Brooke (MHB Executive Director); Ayana Baltrip-Balagas (MHB Administrator); Emeric Kalman, Member of the Public; Michael Wise, Member of the Public.

CALL TO ORDER

The meeting was called to order at 6:30 p.m. by James L. McGhee (Vice-Chair).

ROLL CALL

Ms. Brooke read the roll.

Item 1.0 DIRECTORS REPORT

CORRECTION: In last month's minutes for March 14, 2007, Dr. Alice Gleghorn's name was misspelled. We apologize for this error.

Monthly Director's Report

April 11, 2007

1. CBHS Integration.

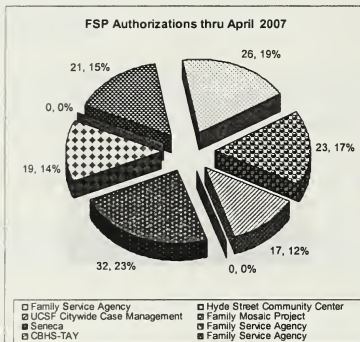
Zialogic will be arriving for its **Quarterly consultation** on **April 13, 2007**. They will meet with Prevention Providers from 9-10am and the Integration Advisory Committee from 10-11:30am at 1380 Howard Street, 4th Floor Conference Room. Zialogic will then meet with Change Agents beginning at 11:30am-5pm at the Ba'hai Center, 170 Valencia Street/Duboce.

2. Mental Health Service Act (MHSA) Update.

COMMUNITY SERVICES AND SUPPORTS

Mental Health Services Act (MHSA) - Full Service Partnerships (FSP) :

138 partners have been authorized to receive full service partnership services as of the first week of April 2007. The table below shows the age group of these partners and agencies where they were referred to:



AGENCY	Total
Family Service Agency	2
Hyde Street Community Center	2
UCSF Citywide Case Management	1
Family Mosaic Project	
Seneca	3
Family Service Agency	1
CBHS-TAY	
Family Service Agency	2
Total	13

MHSA – Housing Service Partnerships (HSP) :

Of the twenty two (22) stabilization units available for FSPs, nineteen (19) are occupied through March 2007. Three partners are currently applying for permanent housing units and awaiting approval from Tenderloin Neighborhood Development Corporation (TNDC).

Six Transitional Age Youth partners are in permanent housing.

WORKFORCE EDUCATION AND TRAINING:

The final guidelines for the Three Year Plan with the allocated amounts for each county will be disseminated by Department of Mental Health towards the end of April. This information will also be available on the MHSA web site at: <http://www.dmh.ca.gov/mhsa/EducTrain.asp>.

Community Behavioral Health Services will initiate a series of six planning meetings starting on

Thursday, April 12, 2007, from 4 to 6 pm at 1380 Howard Street, 4th Floor Conference room, including a community meeting on May 3, 2007, at Friendship House, from 3 – 5 pm. These meetings will be led by the MHSA Workforce Education and Training Planning Committee co-chaired by Toni Rucker, CBHS Director of Training and Dina Redman, Assistant Professor SFSU School of Social Work. Community members, especially consumers and family members, are invited to give their input to the committee to enhance, expand, and improve workforce development through MHSA-funded education and training initiatives. Flyers will be distributed to all mental health agencies and affiliated organizations.

MHSA HOUSING PROGRAM:

We are still waiting for the draft of the local plan requirements to be released by DMH. In the meantime, a plan is underway to meet with the Housing and Urban Health unit to develop the planning guidelines for the City & County of San Francisco.

PEER AND STAFF TRAINING SCHEDULES

Coping with Depression - The Mental Health Association of San Francisco is holding an 8 week workshop on Coping with Depression every Thursday from March 15 – May 3, 2007 from 5:00 pm – 7:00 pm in the SOMA/Civic Center area. This **free** training is open to mental health consumers who are part of the Community Behavioral Health Services (CBHS) Peer Intern program or mental health consumers *working* at CBHS programs or CBHS-funded non-profit contractor agencies.

How Will Working Affect My Benefits – A free training sponsored by the Mental Health Association of San Francisco will be held on May 1, 2007, at a location downtown. This free training is open to consumers of San Francisco's public mental health system who receive SSI and/or SSDI and are thinking about going back to work or who are currently working. To register for this training contact - Attn: Benefits Training, MHA-SF, 870 Market Street, Suite 928, San Francisco, CA 94102. Fax: (415) 421-2928. Email: registration@mha-sf.org

A Free Showing of the Documentary Movie "The Bridge" – The San Francisco Mental Health Board and Community Behavioral Health Services are cosponsoring this free showing. This documentary chronicles those who attempted to jump off of the Golden Gate Bridge over the course of 2004, and will feature an interview with survivor John Kevin Hines at the end of the movie. This movie will be shown on Wednesday, May 16, 2007, from 6:30 – 9:00 pm, at Dolby Laboratories, 100 Potrero Avenue, San Francisco, CA 94103. Viewer discretion is advised. Reservations required. Limited seating.

3. Other Upcoming Events:

Safe Workplace Violence Prevention – What you can do to keep yourself, your coworkers, and your clients safe at work by Mike Arraj – May 18th, 8am-12pm OR 1pm-5pm.

Advanced Motivational Interviewing in an Integrated Behavioral Health System by Dee-Dee Stout – May 31st, 8:30am-4pm. Please note that you must have attended the beginner/intermediate course prior to this training.

To register for these trainings, please contact Norman Aleman, CBHS Training Coordinator at 415-255-3553 or email norman.aleman@sfdph.org

May 9 & 10 - All-Staff Meeting - CBHS Adult/Older-Adult. CBHS is holding its *2nd All-Staff Meeting of all employees* working in mental health and substance abuse treatment programs *within the Adult/Older-Adult Systems-of-Care*. At least 1,500 estimated staffmembers from across contractor and county-operated programs will attend this *big event*, which will take place at the Bill Graham Civic Auditorium, 99 Grove St., *over a 2-day period* on Wednesday May 9 and Thursday May 10, which will afford all programs the opportunity to send half of all of their employees each day (all clinical as well as administrative staff), and keep their programs open with skeletal staffing. The theme of the May 9 & 10 All-Staff Meeting is "Public Health: Helping Communities Navigate Toward Wellness"

The purpose of the Adult/Older-Adult All-Staff Meeting is to foster a sense of everyone being a part of One System-of-Care, to acknowledge the valuable contributions of all CBHS programs and staff, and to develop a shared vision for community behavioral health services in San Francisco during this period, which highlights the importance of integration of services and collaborations across county departments and partner agencies. The all-day meeting (9 am - 4 pm) will also facilitate networking among programs, and sharing of key information, developments and perspectives, including concurrent afternoon workshops on:

- i. Integration of Primary Care into Behavioral Health Services
- ii. Behavioral Health Response to Community Violence
- iii. Treatment Needs of Women Clients in CBHS
- iv. San Francisco's Homeless and Housing Initiatives, and CBHS' Role
- v. Work as a Priority for Recovery: Vocational Services for Clients
- vi. Welcoming Clients at Every Door (presentation by CBHS Change Agents)
- vii. Taking Care of Ourselves: Stress Management Exercises

The most important part of the All-Staff Meeting is our collective acknowledgement of the special contributions of some of our fellow co-workers. Please encourage staff at your programs to submit nominations, for the 2007 CBHS Adult/Older-Adult Recognition Awards to be presented at the All-Staff Meeting, of their co-workers who have shown significant dedication and commitment to improving the lives of persons they serve through their excellence in performance and community contributions. The nomination form they can use, with instructions showing the award categories, is included at the end of this Director's Report. This is our opportunity to acknowledge the excellent work occurring across our system-of-care, and the individuals and teams that make it happen.

I look forward to seeing and meeting everyone on May 9 and 10.

OMI New Location. OMI Mental Health Center has moved to its new location at 1701 Ocean Ave., San Francisco 94112, right across the street from its previous site. The agency's phone numbers are the same. The CBHS Anchor Program, which provides psychotherapeutic services to adults with developmental disabilities, has also transferred to 1701 Ocean Ave., moving from its former location at Sunset Mental Health Clinic. Please update your records.

HAFCI opens 24-Hour Drop-In Center. Last month, Haight Ashbury Free Clinics held the grand opening of "Buster's Place", a new 24-Hour Drop-In Center, located at HAFCI Integrated Care Center, 211 . 13th Street (at Mission Street). HAFCI's 24-Hour Drop-In Center will fill an important need in the community, given the recent closing of the McMillan Drop-In Center. The Integrated Care Center complex, within which the 24-Hour Drop-In Center is located, provides a range of comprehensive health care services, including primary medical care, substance abuse treatment, mental health counseling and intensive case management, all under one roof. To learn more of HAFCI's services, visit <http://www.hafci.org>

Past issues of the CBHS Monthly Director's Report are available at: <http://www.dph.sf.ca.us/CBHS/default.htm> To receive this Monthly Report via e-mail, please e-mail kathleen.minioza@sfdph.org

Dr. Cabaj: "I would like to highlight some areas of the report. Our integration efforts are continuing. We had a very nice presentation in front of part of the Health Commission a few weeks ago about integration and behavioral health with mental health and substance abuse combined. Commissioner Illig was very impressed about the work of our contract groups who are providing the majority of our services now. This is what we like to see. We have to integrate the work of the community providers with the work of mental health.

You can also see in the report a very nice chart outlining our use of the funds from the Mental Health Services Act. Some of our providers are here tonight. The growth of our Full-Service Partnerships continues. We think our services may be full to the level that we budgeted; or that we have received enough money for them by the end of the fiscal year in June. So we are looking at what to do next once we have reached our limit. We will have to wait to see what the Governor will do about to AB 2034.

If the Governor cuts the program and we don't think he will, we will have to use all the additional funding we are now receiving to keep these programs covered under this bill. We will have to wait and see what happens in the May 2007 revisions. Many of you participated in the protests, and there was a large protest in Sacramento this past Monday. We are not making big plans about the Mental Health Services Act's dollars until we see what the Governor will do. We believe cutting the bill is illegal because it runs into supplementation issues.

Workforce and Education training dollars will be announced in a month or so. They have given us some preliminary guidelines and we are starting a planning group to see what we can do this year in San Francisco. The planning group is going to be chaired by Tony Rucker, Community Behavioral Health Services (CBHS) Director of Training, and Dina Redman, Assistant Professor, San Francisco State University School of Social Work. Dina Redmond has been very active on the state level, and I feel she and Ms. Rucker will spearhead a great planning committee. The first meeting is tomorrow—April 12, 2007. We want to have suggestions about what we may want to do with this training money before the end of the summer. Even though the State has not given us clear guidelines yet, we don't want to be behind the curve on any of this.

There'll be more funding specifically for housing coming along under the Mental Health Services Act, but again we do not know how much. I believe they are going to be using the same formula for the funding as they did with the clinical services support. Some of you attended the Oversight and Accountability Commission and spoke up about this issue at the hearings held in San Francisco a couple of weeks ago. The word got out that San Francisco spoke up and talked about the proposed funding not being enough to meet the housing needs for San Francisco. Dr. Katz came and spoke up and I did a brief presentation about how we could identify the specific needs here in San Francisco. We think we can treat up to 1300 more people if we get enough money in the next few months. Apparently our voices were heard and, I don't know if this means they will to revisit the issue, but that is one of the things we hope they will look at.

There are several trainings coming up, and one of the key ones we're having is an all-staff meeting for the adult side of our services. I think in the past some of you have attended our Children's System of Care meeting, which also meets annually. It has been about three years since we have done an Adult System of Care meeting. Edwin Batongbacal is taking the lead on this along with Ernestina Carrillo, one of our new deputy directors on the adult side. We're going to emphasize all the changes that have happened in the last year. This meeting will occur over two days May 9th and 10th, and there will be about 1500 staff members from our transitional youth and older adult contract providers and department personnel attending. We hope to make this meeting both interesting and informative, and we will be giving out awards to staff whose work has been acknowledged as outstanding, as well as other outstanding services. I hope some of you will be able to attend if your schedule allows.

Another piece of news is that the OMI Center in the Ingleside District has moved to a new building. The old building was a source of many problems so it is nice to have them in this new location. We are happy that it is directly across the street from the old location. It has been a smooth transition for both staff and clients. In fact, the space was too large for our clinic alone so we moved in the Anchor Project which is a team that works with our developmentally disabled clients who have severe mental illness. They were previously stationed at our sunset clinic which still didn't have enough space. We're very pleased they are in this new location.

A new drop-in clinic managed by the Haight-Ashbury Clinic is opening on 13th Street where the old VA homeless programs were. Their base will be our replacement for the Macmillan Center. The building is going through an extensive renovation, so come by and see what's going on. It's going to be part of our integrated care for people with chronic physical disability issues, as well as mental health problems. It's exciting that it has opened, and that it's so far successful.

You'll also find in your copy of the Director's Report a form announcing our upcoming awards ceremony. On one side you will see the award categories where we want to acknowledge staff and others. On the other you'll see the form. If you have any recommendations or suggestions, please send them to Steve Banuelos who is collecting that information."

1.1 Director's Report: Board Discussion

Mr. Kalman: "There was a recent survey done by the Human Services Agency on the homeless that you mentioned tonight, and the San Francisco Chronicle, I believe on April 7th covered this survey in an article. What I would like to know it is why this survey doesn't include any information about people who are homeless and suffering from mental illness and drug addiction?"

Dr. Cabaj: "I believe the survey can be found on the Human Services Agency's web site. They seem to have focused on the family situation of the individuals being surveyed—were they in a family unit, where did they come from. I know that they did not look at any physical or mental disabilities that people may have been experiencing. Your question should be addressed to the authors of that report."

Ms. Walker: "Firstly, I would like to thank all of you for your good wishes and your card during the time I was sick. I appreciated it very much. Secondly, I am going to be leaving the board, and I want to thank all of you for your courtesy and support. I have not always been in agreement with what the board is doing."

Mr. McGhee: "Firstly, on behalf of the board I want to acknowledge your tremendous contribution and support and secondly, I personally am sad that you are leaving and feel you add a lot to this board. I know the rest of the board members also feel this way Thank you so much for your great contribution."

Ms. Walker: "Thank you."

1.2 Public comment relevant to Item 1.0

Dr. Moses: "Do you have an update on Proposition 63 and how the money is going to be distributed?"

Dr. Cabaj: "As it stands now, they're going to be using the same formula which doesn't serve San Francisco very well, but the monies for education and prevention may follow a different formula. We aren't sure right now. Mayor Newsom supported us in a letter to the State outlining our need for treating an additional 1300 people, which would actually cost an additional \$26,000,000. It's about \$20,000 per person. We wrote a proposal for \$26,000,000. I don't know if Dr. Mayburg is laughing, but we will see where it goes.

The State cannot make a decision by itself because it has to go through a lot of different processes including the California Mental Health Directors; but we're frustrated with the way the money has been distributed. We are waiting to see what happens. The other California Mental Health Directors have taken the stance not to change the formula because most of the other counties like what they received, and as Barbara Garcia has reminded me, Mayor Newsom and the Board of Supervisors have taken a stance that they don't approve of this formula. So if there are votes that I have to take in terms of the other medical health directors, I'll have to abstain because I cannot support this formula."

Ms. Brooke: "I've had police officers during the police crisis training, tell me that they have dealt with people who have come to San Francisco from other counties. Hopefully this will change since these other counties are getting more money than we are."

Dr. Cabaj: "One of the findings of the homeless count that was done this past January was that over one-third of the people counted were from other areas other than San Francisco. This seems to support what you are saying."

Dr. Moses: "Do you know if Dr. Katz is planning on interviewing people to fill Jimmy Loyce's position?"

Dr. Cabaj: "What I understand is that that position will not be replaced. Most of the services will come into the community programs under Barbara Garcia. So these services will be more closely aligned with Community Behavioral Health and private care. The Health Commission thinks this is a good thing because it's another type of integration and consolidation. However we know that Dr. Katz likes the research and evaluation part of the job which he used to do himself, and that may go back to him; but we don't know for sure."

Ms. Brown: "Does this is recognition award have to be for people only working at 1380 Howard Street?"

Dr. Cabaj: "No, it can be for anyone working in any part of our system —contractors or one of our new peer counselors."

Item 2.0 PRESENTATION: SUPPORTIVE SERVICES FOR HOUSING: Sherilyn Adams, Larkin Street Youth Services; Jackie Jenks, Central City Hospitality House; Gay Kaplan, Curry Senior Center

2.1 Presentation

Mr. McGhee: "I would like to welcome Sherilyn Adams, Executive Director of Larkin Street Youth Services, Jackie Jenks, Executive Director of Central City Hospitality House, and Gay Kaplan, Executive Director of Curry Senior Center. They will give a brief overview of their agencies and then talk specifically about the supportive services they provide under the Mental Health Services Act funding."

Ms. Adams: "Larkin Street Youth Service is an organization that has been around since 1984, and we serve homeless and runaway youth from ages 13 to 24 throughout San Francisco. We started out as a drop-in clinic caring for youth up to the age of 18. Over the next 20 years, we expanded a full range of services now covering youth 13 to 24 years of age. Services include shelters, transitional living programs, scattered site housing programs, education and employment programs, health programs, and programs targeting youth with HIV.

About five years ago, we started developing services to serve youth suffering with mental health and substance abuse issues. We added additional case management support, a consulting psychiatrist, peer substance abuse counselors, and more individual and group counseling around issues of mental health.

Right now, we serve around 2200 youth over the course of the year. About 300 of these sleep with us each night either in our emergency shelters, our transitional youth housing, in our scattered site housing programs, or in our permanent support housing model.

Last year we applied for Proposition 63 funds to expand our housing for youth with mental health issues and for youth with severe mental disabilities coming out of the Children's System of Care. While we had already been serving youth, this was going to be our opportunity to expand housing and supportive services for those with mental health issues.

The total program has three components: one added drop-in services at our adult shelter that serves people 18 to 24. We expanded case management and drop-in services also at our Haight Street referral center. We see about 800 young people at that center each year. It is at this center where we see youth with the most severe problems and who experience the

most difficulty accessing housing. The other component included adding more housing: 18 units of housing, and more services to our day-labor unit. We've expanded services within our educational and employment programs in general.

The focus of the program is to add more housing, add support to people who are trying to get into housing, or who are in our shelter, and to increase the vocational and educational opportunities for them. We have a peer position with our day-labor program. We have two peer positions with the drop-in clinic programs. We have 16 units of supportive housing with two more coming online at the end of this fiscal year.

The housing is either in small single-room housing occupancy hotels, or a studio plus apartments located in different parts of the City. Case managers work with people to stay in the housing and help them develop an independent living plan, and link them to the education and vocational programs at Larkin Street.

By supportive housing, I mean we find a housing unit, pay the rent and hold the lease. Sometimes, depending on the relationship with the landlord, the young person is also put on the lease, and sometimes we hold the lease alone. We also provide all the practical things a person may need for living in an apartment, such as furniture, dishes and linens, kitchen utensils, and other household items. The case manager's job is to do whatever is necessary to make sure that person maintains their housing. They may help the person with the necessary life skills like cooking and cleaning, budgeting, job skills; whatever is necessary. The case manager may also help the youth maintain a connection with their family. If this is not possible, they will help the youth establish a connection with some sort of community base. In addition, the case manager will help the youth link with employment services, and education, as well as health services.

Our education and vocation programs run the gamut from our Day-Labor Program through college support. We link students to programs at City College and San Francisco State University. We help students with the application process; explore financial aid opportunities, study skills, and books. We also offer a full range of services for people who want to work full or part time. This includes job readiness classes and helping people access employment. We will be adding a job coach position that will provide people support in their first six months of employment, staying in more regular contact than we've been able to do in the past."

Our current contract with Community Behavioral Health Services (CBHS) is based on the length of stay in our housing units by our youth. I think that CBHS thinks the length of time a youth stays in housing is from six to eight months, but that is not the case. We think of most of our housing programs as transitional, lasting 18 months or 24 months at minimum. Because of the newness of this type of programming, we were able to have some flexibility in terms of length of time of stay for our youth. We're hoping to see how this works over a period of time.

Some of the people come to us by way of referral; some come directly from CBHS. Other slots are for those who are coming directly out of the Children's System of Care—people who have previously been in a residential setting or a residential group home. These are transitional youth who are turning 18 and don't have a family or guardian to whom they can return. They are coming directly into housing to avoid the experience of being homeless."

Dr. Shukla: "What are the most frequent mental health issues you are seeing in your youth? Can you comment on what brings them to you in their homeless state, or runaway state?"

Ms. Adams: "The mental health issues we see usually center around depression and anxiety related issues—post traumatic stress resulting from child abuse or from witnessing violence in their communities and/or as experienced from being on the streets. As we begin to work more closely with our clients, we may begin to see people with thought disorders. Some of the people we are serving with these funds may have already been diagnosed with the mental illness, or were diagnosed in childhood or adolescence, and were already part of the system of the care. They may be coming to us with more information about their mental illness. The homeless condition for some of these people may be because they have been kicked out of their home because their family could not deal with their illness, or related to other issues."

Ms. Brown: "If the youth are doing well, will Larkin Street transfer over the lease to them?"

Ms. Adams: "Yes. We have a housing program for youth with mental health issues, another for youth transitioning out of the foster care system, and another one for Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) youth. We're always hoping that they can eventually take over their own lease, and we set up systems that will support them in this goal."

Ms. Eichenbaum: "Do you have a breakdown on the gender or sexual orientation of the youth? If so, what are you seeing as far as youth accessing Larkin Street?"

Ms. Adams: "Historically, Larkin Street has seen about 40 percent Caucasian, 25 percent African-American, 15-20 percent Latino. The remainder is comprised of those who are ethnically mixed and Asian Pacific Islander. That's been shifting over time, so now we have more youth of color than Caucasian youth. The primary cause of the shift I would say, is due to the disproportionate numbers of African-American and Latino youth, but primarily African-American youth in the foster care system who are now aging out. In terms of gender, we have slightly more males than females. It depends on the program, but I would say that we are about 60 percent male, 35 percent female, and five percent transgender. About one-third of the youth identify with being LGBTQ, or questioning."

Ms. Eichenbaum: "How do you get clients?"

Ms. Adams: "We do a lot of street outreach, with teams on the streets six days a week at various times and parts of the city where we think youth are to start the process of engagement. We have two drop-in centers, one for youth under 19 years of age, and one for youth up to the age of 24. Word of mouth is the most common way people find out about us. We talk to other groups and service providers to also help spread the word about our services."

Ms. Eichenbaum: "What do you feel you and your staff have learned about youth at risk?"

Ms. Adams: "Larkin Street is for those youths who really have nowhere else to go. They are either too old to go into the child welfare system, or they have no family support system in place. We primarily see the youth most at risk, LGBTQ youth, and those with mental health issues."

Mr. Keys: "What type of life skills are these children given that enable them to succeed once they move into an apartment on their own? Another question that goes along with this is, what kinds of jobs is Larkin Street creating for these children—like working in a bakery or a restaurant where they can get real world job training skills?"

Ms. Adams: "In terms of job skills, that role is taken on by our case managers and counselors. The approach is a hands-on one, where you see case managers and counselors taking an active role in working with the youth to maintain their housing and develop their skills to a point where they can function successfully. We do life-skills building and group activities like putting together shopping groups, and helping youth budget their money around activities like grocery shopping. Our programs at the center are focused around these types of activities. There are a lot of activities around peer relations, how to get along with others, conflict resolution, things like that. In our Day-Labor program which offers paid internships, our staff does workshops on topics like, how to navigate through the workforce, what happens if there is a conflict, those sorts of things. This type of work is our primary focus. We also use volunteers for other types of life skills.

To address your other question about creating jobs, we used to have a Ben and Jerry's program. Now we partner with Juma Adventures who work with getting youth jobs at the ballpark. Their primary contracts are with the ballparks. We also try and find paid internships for the youth based on their interests. We pay for the internships."

Ms. Wright: "I'm familiar with your wonderful program, and appreciate the help you have given me with my son. My question is, what happens once the youth reaches age 24?"

Ms. Adams: "Our goal is to make people self-sufficient so that they are able to move on and pursue a healthy life by that time. If they are not ready, and they continue to need to be in some sort of supported environment, we would continue to work with them in some form of a transitional structure so that the transition goes smoothly. We do have our permanent supportive housing program which may be an option for some. Though we call the housing 'permanent,' it's still at some point transitional."

Ms. Wright: "If the youth have mental health problems, they still are going to have those problems at age 24. What happens to them then?"

Ms. Adams: "They move into the adult system."

Mr. McGhee: "Our next presenter will be Jackie Jenks, Executive Director of the Central City Hospitality House."

Ms. Jenks: "Hospitality House has just celebrated its 40th anniversary this year. We started in 1967 and we were founded by youth who had come to San Francisco from different areas and found themselves homeless in the Tenderloin. It was a program founded by youth for youth. There were a lot of adult volunteers who supported the needs of these youth. Hospitality House evolved over the next 40 years to serve the needs of others in the Tenderloin community. We closed our youth program in 1999, and passed the remaining youth on to Larkin Street, and started focusing primarily on adults. When homelessness became an issue in the 1980s, this primarily became our focus.

We currently have three programs: the Tenderloin Self-Help Center which is open Monday through Friday, 12 hours a day, and houses our wellness program; our Community Arts Program which is 38 years old and is the only free-of-charge arts program in San Francisco; and finally the Men's Shelter Program. All our programs are year-based and they follow the self-help model. Many of our people come from the community. People who are under the influence of any kind of substance can come into any of our programs and receive services. We're going to be adding a new program later this year called the 6th Street Help Center. We were approached by the Department of Public Health to set up this program.

The Mental Health Services Act (MHSA) funds did a few things for Hospitality House. Our peer-based services that received MHSA funds are primarily benefiting our Community Arts Program and our self-help program. The funding we receive for housing led to the expansion of our shelter program. With these funds, we were able to add two aftercare case managers to assist with housing retention, a housing assistance fund, socialization activities and outings, and a weekly housing support group."

Ms. Brown: "Does this is program service women as well?"

Ms. Jenks: "The support services for housing are overseen by our shelter program but are not part of that program. Our shelter program manager oversees the services. It does provide support for women.

We have a bilingual Spanish/English capacity. We also have a weekly housing support group that happens at the Community Art Program site. At these meetings, we cover topics like how to work with your landlord, how to budget, different types of housekeeping skills.

We have no qualifications for our programs other than the shelter requiring that the resident applying must be identified as male. That is the only qualification we have. The only non-drop-in service is the shelter."

Dr. Shukla: "I see you received funding for a behavioral health clinic. What mental health services do you provide your clients? Are they mainly peer-based or general counseling, or is there a more formal structure with a psychiatrist?"

Ms. Jenks: "As I mentioned, our services are mainly peer-based, but we do have some other services that are offered through a combination of Department of Public Health (DPH) and MHSA funds, where people can see a psychiatric intern. We also have a nurse practitioner. These services are mainly provided through our self-help center, but anyone can come and seek them. The interns are there four afternoons per week. The nurse practitioner is there eight hours a week, and a doctor is there two hours a week."

Ms. Eichenbaum: "How are men referred to the shelter, and how long is the wait?"

Ms. Jenks: "There is no referral necessary. Part of our model is that we offer low threshold services making it easy for people to just drop in. People can self-refer or they can be referred by an organization. We don't have any way of rating people. They can just come in, and put their name on a waiting list and check in once the week. In terms of the wait, we probably have 50 people on our waiting lists and we only have 25 beds. People tend to stay in 90-day increments, so we don't have a high turnover rate. The wait can be a month or more. Since St. Boniface, another low threshold shelter closed, we have seen the demand for our services rise, and we've seen more Hispanic men and undocumented workers coming in."

Ms. Eichenbaum: "Has there been any advocacy addressing the issue of the wait list or to create more beds either at Hospitality House or in that neighborhood?"

Ms. Jenks: "There has been a lot of advocacy around replacing the beds that have been lost in the Tenderloin. The Mayor said when he was elected that he wasn't going to build any more shelters, so we are just looking to replace the beds that have been lost. We lost a hundred beds at A Man's Place; we lost 80 at St. Boniface Neighborhood Center, and 25 at

Dolores Street. This was all because these places lost their leases; not because of anything they were doing or even because the city funding was lost. It was because they lost their space. In terms of advocacy, people need to advocate for the reopening of St Boniface. St. Boniface was probably the lowest threshold shelter in the whole city."

Mr. McGee: "Our last presenter is Gay Kaplan who is the Executive Director of the Curry Senior Center."

Ms. Kaplan: "I'm going to first tell you what we do and then talk about how we used the funds we received from the Mental Health Services Act (MHSA).

Curry Senior Center is located in the Tenderloin like Larkin Street and Hospitality House, and we will be celebrating our 35th year. We are a one-stop shopping model, mainly focused on the geriatric population. It's surprising to see how many people are unaware that old people are homeless, and it has taken many years to get funding from our city, state and federal governments. We have been providing homeless services to seniors since our inception.

Curry Senior Center is based on the bio-social-psycho model. What we have at our core is a primary care clinic with physicians, nurse practitioners, and nurses that all do home visits. We feel that when tending to an older population that suffers from multiple chronic diseases, it is essential to do home visits.

Our primary care clinic includes case management, a substance abuse treatment program, and a link to Central City mental health outpatient and home visiting services for older adults. We are affiliated with the North and South of Market Adult Day Care Centers. We also have a meal program funded by Title III, located on the second floor of our main site at 333 Turk Street. We have community services where we have established a link with the Lesbian, Gay, Bisexual, and Transgender (LGBT) older adult population, as well as with the ArC of San Francisco for the developmentally disabled older adult population. Older adult for this population is defined as age 45; age 55 for substance abuse and homeless programs; age 60 for Title III. Two years ago we opened 13 units of permanent housing for chronically homeless seniors.

We have patched together a variety of staff and community programs so that we can provide a continuum of services. We are working very hard with the Department of Aging and Adult Services, as well as the Department of Public Health to support homeless community services.

The funding that we received from MHSA is to hire geriatric nurse practitioners and to get chronically mentally ill older adults who have recently been placed in housing engaged in primary care. We know through experience that older chronically mentally ill adults do not engage or access primary care. So we send nurse practitioners to do home care. We are one of the supportive service providers to direct access to housing.

Our outreach services include case managers, substance abuse counselors, as well as clinical staff that go out to the different hotels where the seniors are residing and leave brochures and information about our services. As I mentioned earlier, it has been very hard to convince people that homeless people exist amongst the aged, and it wasn't until recently, when Supervisor Daly formed the Senior Homeless Task Force, that we were able to get the units identified for homeless seniors.

We are now advertising for a Case Manager position that will link up with partner practitioners. This person will work with the senior client linking them into money management services if necessary, and getting them into social day care, or adult day care. With the closure of the day treatment programs, especially for older adults, adult day care programs are now inclined to attempt to meet the needs of the mentally ill older population.

The other issue we look at when dealing with the geriatric population is when dementia is identified as a co-occurring disorder with substance abuse and mental illness. No one wants to own the dementia patient. Considering Alzheimer's and dementia is critical when looking at mental health issues in seniors. If one's primary diagnosis is dementia, in order to enter the mental health system, they have to have a behavioral issue that will allow them access to that service. In primary care, we are dealing with the demented clients or their chronic illnesses or acute illnesses, as well as helping them manage their behavioral issues. This type of structure creates challenges to the primary care system. We feel that our model has been very robust in that we have been able to partner with mental health programs that have helped many of our primary care providers to deal with this type of client."

Mr. Keys: "Are you able to find housing for these clients who suffering from these co-occurring conditions you mentioned?"

Ms. Kaplan: "CBHS has provided funding for one case manager for homeless seniors, and we found when we looked at our data going back 15 to 20 years, that 70 percent of our clients have co-occurring disorders—mental health and substance abuse issues."

Mr. Keys: "But the dementia is not due to the drug abuse. It's organic."

Ms. Kaplan: "It's often organic, but we do see a lot of alcohol induced dementia. Of the different types of dementias, there are instances when the dementia is brought on by substance abuse.

For the funding for older adults, we have partnered with the Family Services Agency to provide primary care for their Full-Service Partnership clients. We provide a low threshold of services to these clients to help them understand that receiving mental health services is nothing to be ashamed of.

The population that we serve reflects the population of the Tenderloin—very diverse. Unfortunately we cannot meet all the language needs of these people. We have seen people from the Balkan States, Ethiopia, and from the Middle East. The workforce issue for people who are bicultural is a challenge. We have a great difficulty in recruiting, hiring, and maintaining our staff. We are often seen as a training ground for our bilingual and bicultural staff; but we look forward to this enhancement from the funding because it has been a long time in coming.”

Mr. Purvis: “Do you work with On Lok or other overlapping services?”

Ms. Kaplan “Yes we do. The model at Curry Senior Center is very similar to that at On Lok. In fact, Dr. Curry who founded Curry Senior Center was also instrumental in the founding of On Lok, but he chose our model to be the one that is not full-service so that people have choices.”

Mr. Keys: “It might be nice for Curry Senior Center to partner with Larkin Street and have some youth come in and develop activities with the seniors.”

Ms. Kaplan: “That’s a great idea. Thank you for supporting all of our services. We really appreciate it.”

2.2 Board discussion of Possible Board responses to the presentation

There was no Board discussion.

2.3 Public comment relevant to Item 2.0

There was no public comment.

Item 3.0 ACTION ITEMS

3.1 Public comment relevant to Item 3.0

There was no public comment.

3.2 Resolutions.

3.2.a PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of March 14, 2007 be approved as submitted.

Minutes approved unanimously.

Item 4.0 REPORTS

4.1 Report from the Executive Director of the Mental Health Board

Ms. Brooke: "The cake was in honor of Kate Walker who served seven years on the Board. She started in April of 2000. She is beginning to struggle with attending evening meetings. I really admire her courage to keep coming and participating.

I'm in the middle of the Police Crisis Intervention Training week. We have trained nearly 600 officers since we started. One of the officers who has been on the force for more than 29 years shared with me that this has been one of the best trainings he has ever attended. Dr. Moses and Ms. Brown were here at the beginning. Without the support of the Mental Health Board, this training would not exist. I would like to acknowledge Ms. Kellum King and Ms. Brown who spoke yesterday on the Consumer Panel. Mr. Purvis often speaks as well, and Mr. Wise.

I want to mention the screening of the film, "The Bridge." Kevin Hines who is on our board will give a brief introduction. As many of you know, he is in the film. We only have 40 seats, so you need to let me know if you are going to attend the screening. The date of this event is Wednesday, May 16th. Doors open at 6:30 p.m. for check-in. The film will start at 7:00 pm and if people aren't in their seats by that time, their seats will be released. CBHS is co-sponsoring the event and their 40 seats are already completely reserved. They now have people on a wait list.

I have previously seen the film, so if any of you has any questions or concerns, I would be more than happy to speak with you. The film is sad, and I think they could have focused more on what could be done to help people in so much pain. The interview with Mr. Hines talks about his experience on the bridge, but not about what he is doing now."

Mr. Purvis: "Most of the film is interviews."

Ms. Brooke: "The Board needs a volunteer to participate on the Mental Health Services Act Workforce Education and Training Committee. Ms. Brown, you said that the volunteer would have to attend six meetings in order to vote. I will find out if we can have an alternate.

I would like to have a program reviewer for Community Vocational Enterprises. I am also passing out a list of programs that will need to be reviewed. Please put your name by a program you would like to review. We need to do at least five reviews between now and the end of June."

Dr. Moses: "Do you have any status on our becoming a commission?"

Mr. McGhee: "President Peskin suggested we talk with the Health Commission to see if they had concerns with our becoming a commission. We wouldn't gain new status by becoming one. I sit on the California Association of Mental Health Boards, and the majority of member associations are boards."

Mr. Purvis: "I got the sense that they wanted to move toward becoming commissions."

Mr. Keys: "We find that people respond better to 'commissioner' rather than 'board member'."

Mr. McGhee: "I would suggest that we talk to the supervisor who appointed us and get their support. President Peskin recommended that we talk to Barbara Garcia, Dr. Katz, and Dr. Cabaj to get their support."

If I remember correctly, former Supervisor Ma was spearheading this issue, but with her getting elected to the State Assembly, the matter got lost."

Mr. Keys: "Where does this matter stand now; do we take it up with the Executive Committee?"

Mr. McGhee: "The Executive Committee has already voted in support of this change."

Dr. Moses: "The Board voted for this and we need to respect this. Each one of us should advocate for this change."

Mr. McGhee: "I suggest you speak to your appointing supervisor for their support."

Mr. Keys: "Because the Supervisors move at their own pace, I suggest we choose two supervisors to take up our banner."

Ms. Williams: "It feels like we're starting from scratch. I think we need to follow up with Supervisor Dufty who seems to be the one to move this issue forward."

Mr. McGhee: "Supervisor. Dufty said he would support it."

Ms. Eichenbaum: "I have a good relationship with Supervisor Dufty, and will speak with him."

Dr. Moses: "My next question concerns the status of Supervisor Jew possibly filling the Board of Supervisors seat on the Board. Where does that stand?"

Ms. Brooke: "We had Jeffery Tong here tonight from Supervisor Jew's office. He is interested, and he will follow up with taking the next step with the Board of Supervisor's Clerk's office to get the process in motion."

4.2 Report of the Chair of the Board and the Executive Committee

There was no report.

4.3 Planning Committee Task Force Report: Tom Purvis

Mr. Purvis: "We'll probably use the ArC of San Francisco as the venue. We are getting returns from organizations that are nominating themselves, others we will choose. We are nailing down the keynote speaker. I'm not sure where the funding stands at this point. It's possible we could put the event on without any outside money. We will be finishing the details off hopefully at the Executive Committee meeting next Thursday and get a full report out to the board after that."

Mr. McGhee: "It is moving along very well. I want to emphasize to the Board that this is a Board activity not a Planning Committee activity. We need each member to get 10 names to Helynnna. We are trying to get 100 to 125 people in attendance. The ArC of San Francisco is a nice venue, and they can cater the event as well. We can get the whole event done for \$1500-\$2500. We need to get the names by Friday if possible."

The event date is May 31st."

Mr. Keys: "Can we be sent an email and snail mail reminder about sending the names in?"

Dr. Moses: "I want to commend Ms. Brooke and her staff for donating their time. I want to commend you for doing a great job."

4.4 Report by Members of the Board on Their Activities on Behalf of the Board

There were no reports.

4.5 New Business

There was no new business.

4.6 Public Comment to Item 4.0

There was no public comment.

5.0 Public Comment

There was no public comment

Adjournment

Meeting adjourned at 8:33 p.m.

SAN FRANCISCO MENTAL HEALTH BOARD



Gavin Newsom
Mayor

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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, May 9, 2007

City Hall

One Carlton B. Goodlett Place

2nd Floor, Room 278

6:30 p.m.

CALL TO ORDER

ROLL CALL

AGENDA CHANGES

Item 1.0 DIRECTORS REPORT

For discussion.

11:10 a.m. msf
DOCUMENTS DEPT.

MAY - 4 2007

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1.1 Discussion regarding Community Behavioral Health Services Department Report, a report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.

1.2 Public comment relevant to Item 2.0

Item 2.0 PRESENTATION: FAMILY SERVICE AGENCY, BOB BENNETT, CEO

For discussion.

2.1 Presentation: Family Service Agency

2.2 Board discussion of possible Board responses to the presentation.

2.3 Public comment relevant to Item 2.0

Item 3.0 ACTION ITEMS

For discussion and action.

3.1 Public comment relevant to Item 3.0

3.2 Proposed Resolutions

3.2.a PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of April 11, 2007 be approved as submitted.

Item 4.0 REPORTS

For discussion and possible action.

- 4.1 Report from the Executive Director of the Mental Health Board.
- 4.2 Report of the Chair of the Board and the Executive Committee.
- 4.3 Planning Committee Task Force Report: Tom Purvis
- 4.4 Report by members of the Board on their activities on behalf of the Board.
- 4.5 New business - Suggestions for future agenda items to be referred to the Executive Committee.
- 4.6 Public comment relevant to Item 4.0

Item 5.0 PUBLIC COMMENT

Members of the public may address the Mental Health Board on any items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board.

ADJOURNMENT

DISABILITY ACCESS

1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Edwin Batongbacal at (415) 255-3446 (voice) or (415) 255-3449 (TTD). Five days notice before the meeting will help to ensure the presence of an ASL interpreter or sound enhancement system. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.
2. Meetings are held at City Hall, One Dr. Carlton B. Goodlett Place (between Grove and McAllister), in Room 278. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and 71 Haight/Noriega. Also, the J, K, L, M, and N lines underground. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.
3. City Hall is accessible to wheelchairs. Elevators, doorways, restrooms, and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on One Dr. Carlton B. Goodlett Place.

4. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City accommodate these individuals.

POLICY ON CELL PHONE, PAGERS, AND ELECTRONIC DEVICES

The ringing of and use of cell phones, pagers, and similar sound-producing electronic devices are prohibited at this meeting. Please be advised that the Chair may order the removal from the meeting room of any person(s) responsible for the ringing or use of a cell phone, pager, or other similar sound-producing electronic devices.

KNOW YOUR RIGHTS UNDER THE SUNSHINE ORDINANCE

Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review. For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact:

Frank Darby
Sunshine Ordinance Task Force
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689
Telephone: (415)554-7724
Fax: 4(15) 554-5163
E-mail: sotf@sfgov.org

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To view Mental Health Board agendas and minutes, you may visit the MHB web page at: www.sfgov.org/mental_health. You may also go to the Government Information Center at the Main Library at Larkin and Grove in the Civic Center. You may also get copies of these documents through the MHB office at 255-3474.

Lobbyist Registration and Reporting Requirements

Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance [SF Campaign & Governmental Conduct Code 2.100] to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; web site www.sfgov.org/ethics.

MENTAL HEALTH BOARD OF SAN FRANCISCO



Save the Date!



The San Francisco Mental Health Board is having an Awards Reception on the evening of **Thursday, May 31, 2007** from 6 pm to 8 pm at The ArC of San Francisco, located at 1500 Howard Street at the corner of 11th Street.

For a full description of the event please visit: <http://mentalhealthboardsf.org/new/>

This is a free event and all are welcome. Please R.S.V.P. by calling **415-255-3473**

WEDNESDAY, MAY 9
2:00-5:30 PM

Millberry Union Gymnasium
500 Parnassus Avenue UCSF Medical Center

IRAQ WAR TEACH-IN

The Health Effects of the Iraq War

**This symposium will
focus on the impact
on combatants,
Iraqi citizens and
the United States,
featuring local,
national and
international
speakers
from the UCSF
community and
beyond, including:**



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Government,
Harvard University

Robert Scheer
author, editor, columnist

Evan Lyon
Harvard Medical School

Richard Garfield
Dept. of Nursing,
Columbia University

Dahlia Wasfi
Global Exchange,
Iraqi-American
Physician

Haile Debas
Former Chancellor
and Executive Director,
UCSF Global Health
Sciences

William Schecter
Dept. of Surgery,
SF General Hospital

Karen Seal
Dept. of Medicine,
SF VA Medical Center

Jess Ghannam
Dept. of Psychiatry,
UCSF

Charles Marmar
Dept. of Psychiatry,
SF VA Medical Center

Salam Ismael
Iraqi Physician (video)



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SAN FRANCISCO MENTAL HEALTH BOARD

Gavin Newsom
Mayor

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UNADOPTED MINUTES

Mental Health Board
Wednesday, May 9, 2007
City Hall, Room 278
San Francisco, CA 94102

BOARD MEMBERS PRESENT: Rebecca Turner, Ph.D. (Chair); James L. McGhee (Vice-Chair); James Shaye Keys (Secretary); Bridgett Brown; Jeanna Eichenbaum, L.C.S.W.; John Kevin Hines; LaVaughn Kellum King; Dr. Toye Moses, Ph.D., M.P.H.; Tom Purvis; M.P.H.; Lisa Williams; Virginia Wright.

BOARD MEMBERS ABSENT: Claudia Lebish; Jagruti Shukla, M.D., M.P.H.

OTHERS PRESENT: Helynna Brooke (MHB Executive Director); Ayana Baltrip-Balagas (MHB Administrator); Benito Casados, Member of the Public; Emeric Kalman, Member of the Public.

CALL TO ORDER

The meeting was called to order at 6:34 p.m. by Rebecca Turner, Ph.D. (Chair).

ROLL CALL

Ms. Brooke read the roll.

DOCUMENTS DEPT.

Item 1.0 DIRECTORS REPORT

JUN - 8 2007

Monthly Director's Report May 9, 2007

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PUBLIC LIBRARY

1. **May 9 & 10 - All-Staff Meeting - CBHS Adult/Older-Adult.** CBHS is holding its 2nd All-Staff Meeting of all employees working in mental health and substance abuse treatment programs within the Adult/Older-Adult Systems-of-Care. The event will take place at the Bill Graham Civic Auditorium, 99 Grove Street on Wednesday May 9 and Thursday May 10, which will afford all programs the opportunity to send half of all their employees each day (all clinical as well as administrative staff), and keep their programs open with skeletal staffing. The theme of the May 9 & 10 All-Staff Meeting is "Public Health: Helping Communities Navigate Toward Wellness."
2. **Community Behavioral Health Services (CBHS) Integration.**

Leadership Training: Dr. David Mee-Lee will present on June 14th for a full day of training with Change Agents at the Phillip Burton Federal Building, 450 Golden Gate. The first session

is tailored to the Charter Member Agents from 8:30AM to 12:30PM and will focus on person centered, integrated, stage-matched treatment planning and the role of MI. The second session, from 1:00PM to 5:00PM is geared toward New Change Agents and Volunteers and will focus on: how to address and facilitate the blending of cultures (substance disorders and mental health treatment) especially as it comes into play when practicing harm reduction; reasons and strategies for creating a “welcoming” system of care; and how to concurrently focus on addiction and mental health recovery. Visit the SFChangeAgents@yahoo.com or contact 255-3553 or 255-3687 for more information.

Change Agent Orientation: Committee members Bonnie Schwartz and Maryanne Mock were the hosts of the final Change Agent Orientation training for FY06/07. There were 14 new Change Agents in attendance from the following programs: Progress Foundation, Positive Directions, SF Homeless Outreach, SFGH Infant Parent Program, Mobile Crisis, Youth Leadership Institute, CASARC, Oholoff Recovery Programs, Urban Services, Homeless Prenatal, Potrero Hill Zap Project, and Bayview Hunter' Point. *Welcome to all of the new members!* Please be reminded to contact your Program Manager directly for technical assistance, support or any questions you may have.

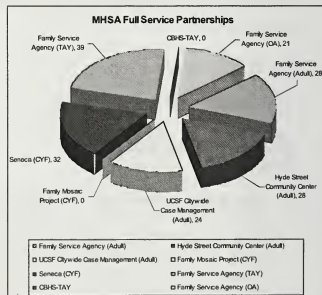
Change Agent Monthly Meeting will be held on May 24th from 9:00AM to 11:00AM at 1380 Howard.

3. Mental Health Service Act (MHSA) Update.

Full Service Partnerships (FSPs) :

172 partners have been authorized to receive full service partnership services as of April 30, 2007. The chart and table below show the age group of these partners and the agencies where they were referred to:

AGENCY	Total
Family Service Agency (Adult)	28
Hyde Street Community Center (Adult)	28
UCSF Citywide Case Management (Adult)	24
Family Mosaic Project (CYF)	0
Seneca (CYF)	32
Family Service Agency (TAY)	39
CBHS-TAY	0
Family Service Agency (OA)	21
Total	172



MHSA – Housing Service Partnerships (HSP) :

Of the twenty two (22) stabilization units available for FSPs, nineteen (19) are occupied through April 2007. One older adult partner has recently moved into a permanent housing unit. Six Transitional Age Youth partners are in permanent housing.

General Systems Development:

The total numbers for unduplicated clients served in the third quarter of the fiscal year (January 1 through March 31) are as follows: 97 in CYF programs, 122 in TAY programs, 119 in Adult programs, and 101 in Older Adult programs. The total number of unduplicated clients served to date is 673.

MHSA Implementation Progress Report :

The 30-day public comment period has begun, as of May 1, 2007. This report documents the challenges and achievements made by our Community Supports and Services network through December 31, 2006. This report is posted at the CBHS-MHSA website at <http://www.sfdph.org/Prop63/default.htm>. Public comments can be emailed to prop63@sfdph.org, faxed to 415-255-3529 or mailed to Kevin Ledbetter, MHSA Administrative Assistant, 1380 Howard Street, 4th Floor, San Francisco, CA 94103. For questions about the report, please call is (415) 252-3084. All calls will be returned within 24 hours. The public comment will end at close of business on May 30, 2007. The public hearing by the local Mental Health Board will be held at their regular monthly meeting on Tuesday, June 13, 2007.

Fiscal Year 2007-2008 Budget:

DMH requires that all counties conduct a thirty-day public comment period for the FY07-08 additional MHSA CSS funding. To comply with this requirement, the Mental Health Board will present the budget at their regular meeting on June 13, 2007, initiating this public process.

WORKFORCE EDUCATION AND TRAINING:

Three Advisory Committee meetings have been held in order to develop a Three Year Plan, including one meeting devoted solely to public comment. The dates of remaining meetings to be held at 1380 Howard Street, 4th floor main conference room, include: Thursday, May 17, 2007, 1:30 - 3:30 pm; Thursday, May 31, 2007, 10:00 am – 12 noon; and Thursday, June 7, 2007, 10:00 am – 12 noon.

4. Other Upcoming Events:

Advanced Motivational Interviewing in an Integrated Behavioral Health System by Dee-Dee Stout – June 1st, 8:30am-4pm. Please note that you must have attended the beginner/intermediate course prior to this training

Vietnamese Family Wellness Conference - June 1st, 8:30am-4pm, Pickleweed Community Center, 50 Canal Street, San Rafael. The goal of this conference is to bring together behavioral health clinicians and social service providers serving the Vietnamese community in the Bay Area and beyond to share experiences, resources and ideas to address health disparities and improve family wellness.

San Francisco Sexual Offender Treatment Provider Certification Training – June 5-6, Location to be determined. This training is for psychologists and social workers who provide services or make referrals for sex offender treatment.

CBHS 5150 Training – June 6th, 8:30am-1pm, Philip Burton Federal Building. All Mental Health ADULT Services staff who wish to initiate the 5150 process for clients must complete this training once every 5 years. This training is being offered to all acute, subacute, residential and outpatient **mental health** services staff and certifies staff to utilize the 5150 privilege. This training is also directed **toward those who are interested in becoming designated trainers for their own program**. This training will cover basic administrative issues related to the 5150 application as well as core skills and competencies. Designated trainers must be one of the following mental health professionals: MD, RN, LCSW, MFT or licensed PhDs. Waivered or registered interns will ALSO qualify as designated trainers.

Suicide Prevention: State of the Art and Science – June 19th, 8am-5pm, Fort Mason Center, Kenote speaker Douglas G. Jacobs, MD. Suicidal behavior, whether attempted or completed is always a devastating event for the individual, her or his family and friends and for the providers. SF Community Behavioral Health Services attaches great importance to the prevention of suicidal behavior. Because of the importance of this clinical issue, this quarterly medical staff meeting invites all providers and interested consumers to attend. The focus of this one-day conference is to enhance clinicians' skill in the diagnosis and management of suicidal behavior. We will discuss the current art and science of suicide prevention from several perspectives: adult, child and adolescent, suicide survivor, epidemiologic, programmatic and medico-legal. Cases will be presented to the keynote speaker for discussion.

To register for these trainings, please contact Norman Aleman, CBHS Training Coordinator at 415-255-3553 or email norman.aleman@sfdph.org

Past issues of the CBHS Monthly Director's Report are available at: <http://www.dph.sf.ca.us/CBHS/default.htm> To receive this Monthly Report via e-mail, please e-mail kathleen.minioza@sfdph.org

Dr. Cabaj: "Today was the first day of our all-staff meeting. We are having an identical program tomorrow, so if of you want to hear an update about where we are going and attend workshops please come by. Ms. Brooke was part of a panel on women issues. It was a very busy day. We had around 500 people in attendance. Dr. Katz came by. We had half in attendance today and hope that the other half will be here tomorrow, so that all our providers—our community based organizations and civil service staff will be updated.

We are continuing our integration efforts. This was the big highlight of our meeting today. Dr. Ming Lee is back in June to help with furthering integration teaching. The change agents group is getting larger.

Nearly all of our Full-Service Partnerships spots are full. This is good in that the programs are up and running, but bad in that we were hoping to continuously expand capacity. As I mentioned at last month's Board meeting, Dr. Katz and I sent a letter to the State asking for more money to fund more slots. We could bring in 1300 new people each year if we had the funding. This number may be on the low end. The State hasn't responded yet.

More money is coming at some point. We will be able to maintain all our programs with the current budget. We funded three adult programs, and there was some worry that we would not be able to keep all of them. We hope to be able to use our increase in funds to keep all three. There shouldn't be a problem. I don't believe the Governor's May revised budget is out yet. He is still threatening to cut AB 2034. So many of you have been very helpful by attending the protests against this proposed action. There will be another large

protest coming up, on May 24th I think. If we get more funds, we will look to the MHB as our advisory committee on how to use the funds.”

Ms. Brooke: “Mr. Hines received a response from the Governor to a letter he wrote to oppose cutting AB 2034 funds.” [Ms. Brooke read a portion of the Governor’s letter.]

Dr. Cabaj: “That’s great. We are hoping the Governor will get the message. As I’ve mentioned in the past, most organizations have interpreted the Governor’s move as illegal if he tries to take away AB 2034 funds, and use the mental health supplement instead. This action is viewed as sub-plantation.”

Mr. Hines: “The Governor says in the letter that it is not sub-plantation.”

Dr. Cabaj: “All the lawyers on the other side are saying it is a problem. We hope to use the money from the new budget to keep the service level current or maybe expand it a bit for next year. If we get more funds, we will look to the Mental Health Board as our advisory committee on how to use them. As it stands now we have enough to keep services as they are. The Governor makes the final decision, and next week the budget revision comes out. We also will get the Mayor’s budget at that time, and we are waiting to see what the domino effect may be if the State makes changes.

There are challenges to what the Governor is proposing, but I’m not aware of any legal challenges. He could do the change and it could get rescinded later, but a lot of grief and stress could occur during that period. We are all hoping he will get the message.

As part of our work with the Mental Health Services Act, it is time for our annual review and progress report. It is a very well written document, so I hope you have time to review it. We will be having public hearing on this next month as part of the Mental Health Board’s regular meeting. We will be consolidating public comment from this hearing, and getting them back to the Department of Mental Health by the end of next month June.

We are working on a plan with the workforce development program, which is a part of the Mental Health Services Act funds and includes education training. As mentioned in the past, the Workforce Task Force is being chaired by Dina Redmond, of the University of California San Francisco, and Toni Rucker, head of our training at the Department of Public Health. We are actually ahead of the State in the work that we’re doing in this area.

We hope to soon get guidelines around intervention and early prevention strategies. We will be holding a strategic planning process that won’t be as extensive as the one of we last held, but we will still hold enough meetings to get the valuable input from the community.”

Dr. Turner: “When do you think we will need to have another public hearing after this one in June?”

Dr. Cabaj: “One of the processes doesn’t require a hearing but we hope to have things in the place by the end of June. The early intervention and prevention plan may require a hearing, but I’m not sure. We will definitely present our plans to the Board for input, but I don’t believe that a public hearing is required.”

Dr. Turner: “What kind of feedback is the Department looking for that will be most effective?”

Dr. Cabaj: “This report will be an update on what we have accomplished since we’ve developed and rolled out the plan. It turns out that we still are way ahead of most counties. We would like to have feedback on how we are accomplishing our stated goals. If we are

saying we are doing certain things, and you find we are not, we would love to hear that feedback. The public hearing we had in the past helped us correct some data, so although the factual information is very straightforward, if you find something incorrect, we need to hear it."

Dr. Turner: "What happens to the feedback; does it go to the State?"

Dr. Cabaj: "It becomes part of a summary we then submit to the State."

On the last part of tonight's Director's Report, you can see some workshops are coming up and some other trainings."

Mr. McGee: "How many Community Behavioral Health Services directors are there?"

Dr. Cabaj: "There are around eight directors."

1.1 Public comment relevant to Item 1.0

Mr. Casados: "The training report does not have to be presented to the board. It can be sent directly to the State. I wanted family members and consumers involved in the process, and wanted the Board involved; but I was told that this step did not have to happen. Hopefully, this will change in the future."

1.2 Director's Report: Board Discussion

There was no Board Discussion.

Item 2.0 PRESENTATION: FAMILY SERVICE AGENCY, BOB BENNETT, CEO

Dr. Turner: "I would like to welcome Bob Bennett, Executive Director of the Family Service Agency. He will give a brief overview of his agency and then talk specifically about the Full Service Partnership services they provide under the Mental Health Services Act funding. This is the program that Benito Casados is now working for."

2.1 Presentation

Mr. Bennett: "The Family Service Agency was founded in 1889, so it is 118 years old, with a budget of about 12 million dollars, 70 percent of which is from Community Behavior Health Services. We provide more than just mental health services. About 90 percent of the teen mothers in San Francisco are serviced by our agency. We have the largest childcare center in San Francisco, and it was the first center in the State to service developmentally disabled children in a regular preschool program. It started doing this about three years ago and is still in service today.

Our mental health programs go across the age spectrum. We have two programs in the Children's System of Care, one that does consultation in early childhood mental health through childcare centers, and the other is called the Tenderloin Family Program that focuses on the mental health services in the schools for high school kids.

We have a whole array of programs for adults and seniors. Our senior programs are the largest in the city. We have two large senior mental health outpatient clinics, senior peer counseling, and a senior companion program.

We were able to fund four programs using Propositions 63 (Mental Health Services Act) funds. We got three Full Service Partnerships—one for transitional age youth, one for adults, and one for seniors. We got a senior drop-in program funded as well. It is at the Curry Senior Center. It is in conjunction with Curry Center's meal program and operates from Wednesday through Sunday.

Three years ago we did a strategic plan where we made a deep commitment to implement both a recovery model and evidence-based treatment. I'll briefly go over our evidence-based model. We set up an institute call the Feldman Institute, and our goal was to have the developers of evidence-based treatment approaches train our staff and provide them with ongoing clinical support; so that we could really become outcome focused.

It is our belief that our clients should be served with state of the art services. The cutting edge of mental health treatment has developed greatly over the last ten years. All that new knowledge is not being translated into services for anybody, and especially not in the services for low-income clients. So it is our goal to see that cutting edge treatment models are used for both for psychosocial and psychopharmacological services, and bring it into the community to our clients.

This has turned out not to be quite as easy as we thought. For one thing, one cannot do evidence-based treatments with the caseload of 63, which is the average load for our senior programs. So were working to reduce caseload. We have developed an online client record-keeping program which has cut our charting time in half. By making this change, we have increased by 20 percent the amount of time a client can have with their caseworker.

Another thing we did which is closely tied to the recovery model, is to bring in peer counselors. We went from having a few consumer professional staff three years ago to having 18 now. We rewrote our job descriptions so that the peer counselors would be able to get promoted as they excelled in their work. In the job description, one of the qualifications is preferred experience as a consumer. Initially, the professionals were uncomfortable with this approach. We made it clear to them that a professional is a professional whether a consumer or not and that must be valued. Consumer professionals are held to the same standard as others. This approach is working wonderfully well for our agency.

In terms of the evidence-based treatment, we decided we would focus first on strength-based case management because that is the foundation for everything else. We partnered with Pat Miles who was one of the people who invented wrap-around case management. She has come in and trained all our staff and is now helping them design clinical supervision standards; so that we're really doing strength-based management from the concept of strengths. This approach leads us into the recovery-based model. Part of what we're doing is hiring more peers and making ourselves a consumer-friendly organization.

I believe mental illness - it's just that, an illness, and deserves treatment. The medical model is right on in this respect; but there are social factors that we must look at as well, and the recovery model addresses these. It is not that easy to figure out how to put these two

models together. We have done a lot of studying around this issue of how to bring these two approaches together and what that means to our agency.

Our three Full-Service Partnerships (FSPs) are up a running. I think we have only two slots left in one of them. We have housed 16 people who were homeless when they came to us. I believe we have housed all who have come to let us. Our Senior Full-Service Partnership has 34 partners; our Adult Full-Service Partnership has 28; and our Transitional Age Youth one has 22. These are the limits the county set before giving out the funding. We have a psychiatric nurse practitioner for each program, as well as a supervising psychiatrist. We also set up our programs so that we have partnerships with other agencies. For Transitional Age Youth and our Adult FSPs, CATS provides a substance abuse staff person, and for our Senior FSP, Curry Center provides a substance abuse person. We also have a Goodwill employment specialist for each of our three programs.

Our biggest challenge we are facing right now is finding space. Our budget has increased by 20 percent and we are looking to expand our locations. However, each time a landlord comes to look at our clients, they say they would never rent to us. Then we decided to try to rent space for some of the other programs that were less threatening at and let our Full-Service Partnerships stay in the building that we already own. What we finally did was rent a building that was going to be torn down in two years.

We're moving our geriatric outpatient programs to that building. We are also starting the process of finding a building we can buy so that by the time this building has gone, we will be able to move our services without any problems."

Dr. Turner: "What did the Mental Health Services Act funds specifically help your agency do?"

Mr. Bennett: "The Family Servicing Agency was already following many of the procedures, but we have been able to enhance with the Mental Health Services Act funds. As mentioned earlier, we were able to increase our peer intern positions, and to develop more fully our recovery model implementation.

I think the ideals of the Mental Health Services Act are formidable, but I believe that parts of the county only believe transformation should be happening once the funding has been received by the agency. We believe that transformation should be happening at all stages—the recovery model, consumer orientation, and strength-based management. All these things should be what the whole 200 million dollar county mental health budget is spent on, not just the eight million dollars of the Mental Health Services Act funds we received. Although we were already working with a lot of people, we didn't have a lot of resources."

Dr. Turner: "What percent of your services did the funds support?"

Mr. Bennett: "We did not have housing resources, or flexible funding. Receiving the Mental Health Service Act funds allowed us to expand our services and resources. The County also allowed us to take 25 percent of our funds and use it for development. Setting up our online client base was part of this phase."

Dr. Moses: "Most of your clients come from what areas?"

Mr. Bennett: "Children clients generally come from the Western Addition, Mission, and Bayview neighborhoods. Adult clients are citywide. Senior programs are more geographically divided. We serve all of the western side of the city, and share our Tenderloin work with Central City Hospitality House. We serve eleven language groups."

Dr. Moses: "Does your program serve the diversity of your clients in terms of staff?"

Mr. Bennett: "Our staff is not as diverse as our clients. The County hires away a lot of our staff that speak unusual languages. They pay more. We do really well with hiring and holding on to African American and Asian staff. Not so well with Latino staff. We have protocols we follow to increase diversity in our staff. I think having peers and being able to promote them into higher positions will help boost our diversity numbers. We're trying to break away from the idea that one has to have a Master's degree in order to serve our client base."

Ms. Eichenbaum: "What about dealing with Lesbian, Gay, Bisexual, and Transgender (LGBT) cultural competency? What things are done by the staff to increase their competence level when dealing with this community?"

Mr. Bennett: "Cultural competence is a different issue than dealing with diversity of staff. One can't solve the cultural competence issues just by hiring staff that matches the diversity of the client base. We had one LGBT training about six months ago.

We are doing a celebration of cultures at the agency at the end of a month, which is mandatory for the staff. We're having different staff members come and talk about their own cultures and the different ones in the city.

Our board is about half a lesbian and gay. We really have to work to get people of color on our board, but it seems to be pretty easy to get LGBT representation.

We are the recognized provider for Chinese elderly, especially monolingual Cantonese speakers, and Russian elderly. We do a lot of work to cover all the other languages. We have a very good Tagalog speaking staff. It seems like everyone who is filling a key role in this respect gets hired away. We really struggle with this problem.

Did that answer your question?"

Ms Eichenbaum: "It did. Another question I have is, do you have a corresponding number of LGBT staff not just on the board?"

Mr. Bennett: "We don't know. It is something we would consider a preference for the job, but we really don't know because we cannot ask that question in the hiring process. In terms of sense, though I would say we have quite a few LGBT staff.

Ms. Kellum King: "I'd like to say thank you for hiring Mr. Casados as a staff member, and that the board supports him very much."

Mr. Bennett: "Thank you. We pay more than the market requires. Our base salary is 30 thousand dollars, but we need to pay more to hire the professional quality providers."

Ms. Eichenbaum: "I have one more question. How do people get referred to the family service agency?"

Mr. Bennett: "We have 30 programs, so there are 30 ways people are referred to our agency. The County requires that people be referred to our Full Service Partnerships programs and our intensive management programs. A lot of our clients self-refer, or are referred by other agencies. Through our marketing department, we do a lot of outreach at different fairs throughout the City and County.

For the seniors, especially the monolingual ones, we do in-house contact to attempt to bring them out of their homes and into our clinics to get them the services they needed. We do a lot of this client work and take it very seriously.

We think it is our responsibility to engage the client. If one is not engaging their clients it's either that the services are not appropriate for them, or are not culturally sensitive to their needs. We really hold our staff's feet to the fire and hold them accountable for engagement, and going out to where the clients are. We go anywhere. We go into some really scary places in order to get our clients and stay engaged with them."

Ms. Brooke: Are there any differences in the work you do in regard to gender specific practices?"

Mr. Bennett: "Mostly what we do is unstructured psycho-dynamic therapy. This means that the therapist is trained to respond to the individual needs of the patient. What it often means is that everybody gets the same thing. What we want to do is bring in some gender, sexual orientation, and evidence-based treatments. We are specifically looking at trauma-focussed treatment. Until you put some structure in the treatment, it cannot be tailored to meet the specific needs of the individual. Being human, clinicians are going to see people through the lens of their specific education and training, and not see the individual needs of their clients.

San Francisco has so many slogans: 'Harm Reduction,' No Wrong Door.' So many of these never get beyond the level of slogans or good intentions. When you try to implement them and put them into practice, it's really hard. You not only have to work to get it started, you have to work to keep it going.

We're moving to a model, and we are far from this model, where if a client comes in to see us they get a rigorous diagnosis. They get a baseline assessment of how they are doing based on what their diagnosis is. The client is presented with a range of both pharmacological and psychosocial treatment options. The client gets to pick them, and if they don't work we need to know because we will be monitoring the client. We want to get the mental health treatments to the success that AIDS has had over the last twenty years."

2.2 Board discussion of Possible Board responses to the presentation

Ms. Eichenbaum: "I thought it was a thorough and very humane presentation."

Dr. Turner: "It was interesting to hear him talk about what the MHSA funds did. It is helping them to serve more people than they otherwise would. They felt very poised and positioned to move forward. He really seemed to care about evidence-based treatment. I hear that coming from his philosophy, and his staff is not quite there yet. It's also difficult

defining what these evidence-based treatments are, because there are only so many, and they are not appropriate for every disorder. It's very complex."

Dr. Moses: "He's proud of his accomplishments. My concern is with their diversity outreach and their ability to address the different issues."

Dr. Turner: "It sounds like they are not able to do this well with the Latino population, but are having success with other groups. It should be commended."

Ms. Kellum King: "As a mom, it was good to hear that young people could get employment, that they don't stigmatize these clients."

Mr. Hines: "It was good to hear the story about the youth who worked up to the position of case manager, and that you don't need a Master's to do that job."

2.3 Public comment relevant to Item 2.0

Mr. Kalman: "What is your financial future?"

Mr. Bennett: "I came to the agency in September three years ago. The previous administration operated under a \$300,000 deficit.

The increase for my first year was \$3000. The second year increase (2006) was \$200,000, and I'm hoping to show a similar increase for this year. We are actually one of the more stable non-profits now.

Mr. Casados: "The LGBT issue is being covered. The money is being well spent. More clients are being reached. I am working as a peer intern in one of the Full Service Partnerships, and we are reaching clients that have never been reached before. I see how the services work. We meet the clients where they are at. We go into hotels, the shelters. We meet their needs instead of trying to have them meet ours.

One of the first things we ask is 'what do you want'. You should see the response we get. People that would not go see a psychiatrist are often willing to go once we have spent a few days with them. I've had three clients who, in other programs would not take their medicines. They could not get them med-compliant. Today, they are compliant through the work I have done with them. These are the types of things the Full Service Partnerships are doing. People that haven't been reached are being reached."

Item 3.0 ACTION ITEMS

3.1 Public comment relevant to Item 3.0

There was no public comment.

3.2 Resolutions.

3.2.a PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of April 11, 2007 be approved as submitted.

Minutes approved unanimously.

Item 4.0 REPORTS

4.1 Report from the Executive Director of the Mental Health Board

Ms. Brooke: "In regard to program reviews, Mr. McGhee has done one of Community Vocational Enterprises. I would like to talk to some of you after the meeting to discuss programs you want to review. Some of the programs want us to do the reviews mid-June. They are just getting ramped up with their Proposition 63 supported services and would like a month before we go in. We need to do four more reviews by the end of June.

The Police Crisis Intervention Training is happening again on June 18-22, 2007. I need people for the June 19th panel.

Mr. Purvis will give a report on where we are with the May 31st event as part of the Planning Committee's report.

We are showing the movie *The Bridge* on May 16th. We have to submit a list of names for security reasons. The response was so great that we are going to have a second screening, and I'll let you know that day as soon as the first screening is over. Training is paying for us to rent the movie again.

Mr. Hines will introduce the film as well as provide a Question and Answer segment. It's being co-sponsored by the Mental Health Board and CBHS. The Marin Mental Health Board is also very involved. They were the ones who got us the contact with Dolby and the film's producer. A lot of the Marin Mental Health Board members and county staff will be attending. It's really exciting that this event is bringing together the Mental Health Boards of the two counties. The goal is ultimately have a discussion that goes on after this."

4.2 Report of the Chair of the Board and the Executive Committee:

Dr. Turner: "I think we should thank you, Ms. Brooke for your hard work. With all you have going on, you've been great, and I just want to say thank you.

There are many 'thank you s.' This Board has done phenomenal work. Mr. Hines, it's exciting to have you as the moderator for the screening of *The Bridge*. Mr. McGhee, you have done so much work on the Awards Reception, and Mr. Purvis, Ms. Williams, Ms. Wright, Mr. Keys, and Ms. Brown.

I also want to thank those of you who are also participating on the MHSA Task Force Advisory Group, Ms. Wright, Ms. Kellum King, and Ms. Brown. It's really important that we keep our voice there, and I really appreciate your efforts.

I am very excited about the Mental Health Board's sponsorship of the movie, *The Bridge*. We are actually showing it twice since so many people wanted to attend. Kevin Hines will be leading a question and answer period after each showing.

It will be a busy month because we also have our Awards Reception coming up on May 31st. If you haven't given your names of people who you would like invitations sent to, please give them to Ms. Brooke as soon as possible. Also, feel free to just bring friends and family to the event. We are hoping for a really good turnout.

Our June 13th Board meeting is another very important date. CBHS has completed its Annual Update for the Mental Health Services Act. You received a copy by mail. The Mental Health Board will hold a public hearing at its next meeting on the Annual Update. Please review the update before the next meeting so that you are prepared to discuss its contents.

Also, between now and the end of June we need to complete our program reviews. We are going to expand to other CBHS programs that are not receiving MHSA funds because many of the programs receiving funds haven't really ramped up yet, so some of those reviews will be in the new fiscal year. So please let Helynnna know if there are particular programs you would like to review."

4.3 Planning Committee Task Force Report:

Mr. McGhee: "I would say the planning is three-fourths done. We need to finalize the program and the award plaques.

The ArC is confirmed as the venue. They will also do the catering. We haven't worked out the menu yet. Each table will have a white cloth and candle. The event will happen downstairs by the water fountain. Two sides will be opened up. The food will be set up in the boardroom. We'll have non-alcoholic beverages. The ArC will also provide the servers. We're expecting a turnout of between 75 and 100. The overflow can stand upstairs. It's a nice venue. Even though the Planning Committee has done a great job, I want to impress on the Board that this is 'our' event. Please try to get at least ten people there."

Dr. Turner: "Be sure to read the MHSA document before our public hearing next month."

4.4 Report by Members of the Board on Their Activities on Behalf of the Board.

Mr. Hines: "I attended the American Association of Suicidology (AAS) conference. I spoke twice about two different topics. I learned a great deal about suicide. I can bring information about what I learned to a future meeting. It was a very humbling experience. I went to a presentation by Thomas Jordon who wrote Why People Die by Suicide. It's a fascinating book. They are looking at people with mental illness who die by Suicide. The AAS is trying to find a way for all suicide organizations to better work together.

I also went to Seattle, Washington and spoke to the school where Bill Gates and Steven Jobs graduated from. They both fund the school completely. I was also in Philadelphia speaking on suicide. I hosted the Dee Dee Hirsch "Erasing the Stigma" awards. We awarded Broadway actress Jennifer Holliday, along with others."

Mr. McGhee: "I serve on Conard House's Board of Directors, and would like to know if Mr. Casados can speak one minute at the Conard House's public hearing?"

Mr. Casados: "I'm speaking tomorrow as a client at CBHS's All-Staff conference at 11:30 a.m. I got a chance to share my story from the time I came into the system when they had only the medical model—treating the disease, not the patient. Now I can give back to the community. I get to meet these people at their level, and I see myself 10 to 12 years ago. Boards like this taught me that the point of view of the client must be valued. I got a chance to represent those people who can't represent themselves. I have to thank you because being on this board taught me that I could do this."

Ms. Kellum King: "I'm involved with FAST—Families Against Stigmatization from the classes I taught for NAMI. I am walking to raise money, so if anyone wants to contribute, please see me."

Unfortunately, I recently lost a niece who overdosed, but out of bad things come good things. There is a community group—Community Network for Survivors. They hired me part-time to assist them.

On the second of June, we are having a luncheon to raise money to help send young people to college.

I had the opportunity to read one of my poems to Jesse Jackson who was here making a speech, and he invited me to come read it in Chicago.

I am getting an award at the Presbyterian Church on Ocean Avenue this Sunday. I am very grateful for how my Higher Power is using me."

Dr. Moses: "I happened to be at that meeting with Jesse Jackson. Ms. King made an emotional presentation. It was so good."

Mr. McGhee: " On May 5th, I was elected President of the California Psychology Board. I learned at this meeting that in California, we have 18,000 psychologists. This is more than all the other states combined."

4.5 New Business

There was no new business.

4.6 Public Comment to Item 4.0

There was no public comment.

5.0 Public Comment

Mr. Kalman: "I want to talk about Recreation and Park. They used to have programs for people with physical and mental disabilities. They have a \$400,000 budget for the blind, but nothing for people with mental disabilities.

Let's invite Recreation and Park to come and present or report to the Board.

Adjournment

Meeting adjourned at 8:33 p.m.

SAN FRANCISCO MENTAL HEALTH BOARD



Gavin Newsom
Mayor

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.sfgov.org/mental_health

MEETING OF THE MENTAL HEALTH BOARD

Wednesday, June 13, 2007
Department of Public Health
101 Grove Street
3rd Floor, Room 300
6:30 p.m.

CALL TO ORDER

ROLL CALL

1:20 p.m. msf
DOCUMENTS DEPT.

AGENDA CHANGES

MAY 23 2007

Item 1.0 DIRECTORS REPORT

For discussion.

SAN FRANCISCO
PUBLIC LIBRARY

1.1 Discussion regarding Community Behavioral Health Services Department Report, a report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.

1.2 Public comment relevant to Item 2.0

Item 2.0 PUBLIC HEARING ON THE ANNUAL UPDATE TO THE MENTAL HEALTH SERVICES ACT PLAN

For discussion.

2.1 Presentation: Public Hearing on the Annual Update for the Mental Health Services Act Plan.

2.2 Board discussion of possible Board responses to the presentation.

2.3 Public comment relevant to Item 2.0

Item 3.0 ACTION ITEMS

For discussion and action.

3.1 Public comment relevant to Item 3.0

3.2 Proposed Resolutions

3.2.a PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of May 9, 2007 be approved as submitted.

Item 4.0 REPORTS

For discussion and possible action.

4.1 Report from the Executive Director of the Mental Health Board.

4.2 Report of the Chair of the Board and the Executive Committee.

4.3 Planning Committee Task Force Report: Tom Purvis

4.4 Report by members of the Board on their activities on behalf of the Board.

4.5 New business - Suggestions for future agenda items to be referred to the Executive Committee.

4.6 Public comment relevant to Item 4.0

Item 5.0 PUBLIC COMMENT

Members of the public may address the Mental Health Board on any items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board.

ADJOURNMENT

DISABILITY ACCESS

1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Edwin Batongbacal at (415) 255-3446 (voice) or (415) 255-3449 (TTD). Five days notice before the meeting will help to ensure the presence of an ASL interpreter or sound enhancement system. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.
2. Meetings are held at City Hall, One Dr. Carlton B. Goodlett Place (between Grove and McAllister), in Room 278. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and 71 Haight/Noreiga. Also, the J, K, L, M, and N lines underground. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.
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POLICY ON CELL PHONE, PAGERS, AND ELECTRONIC DEVICES

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KNOW YOUR RIGHTS UNDER THE SUNSHINE ORDINANCE

Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review. For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact:

Frank Darby
Sunshine Ordinance Task Force
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689
Telephone: (415)554-7724
Fax: 4(15) 554-5163
E-mail: sotf@sfgov.org

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PUBLIC HEARING

JUNE 13, 2007

6:30 – 8:30 PM

On The
**Annual Update to San Francisco's
Mental Health Services Act Plan**

The Hearing will be during the regularly scheduled Mental Health
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3rd Floor, Room 300
6:30 p.m.

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SAN FRANCISCO MENTAL HEALTH BOARD



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Wednesday, June 13, 2007
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ROLL CALL

12:20 p.m. msf
DOCUMENTS DEPT.

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Gavin Newsom
Mayor

San Francisco Department of Public Health
Robert Paul Cabaj, MD
Director, Community Behavioral Health
Services

MEMORANDUM

DATE: June 1, 2007

TO: Mental Health Services Community

FROM: Bob Cabaj, M.D.

RE: FY 07-08 Mental Health Services Act (MHSA) Growth Funds

Attached you will find San Francisco's budget delineating the plan to spend the FY07-08 growth funds. We received this funding because the State received excess income tax revenues last year from the additional 1% tax levied on Californians with incomes above \$1 million.

The attached budget plan proposes to continue funding two additional adult full service partnerships, housing for these additional full service partnerships, one additional trauma and recovery service agency and one additional adult peer based center. These added services totaling \$1,169,020 were funded in FY06-07 with prior year funds and were approved by the Department of Mental Health. In addition, we are proposing to increase the effort of the MHSA Administrative Assistant to a full time position (\$31,748), transition the as needed consumer public health aide positions to part-time with benefits (\$129,203) and fund the training and support for peer staff to be provided by the Mental Health Association of San Francisco (\$50,000). These efforts would continue to support the hiring of mental health consumers within our system. Also included is \$257,963 to fund the annualization of existing positions that were budgeted for nine months only in FY06-07. Incorporated in the plan are two initiatives that would support the Community Services and Support programs and promote the principles of MHSA. The first is a request for additional housing for adults, older adults and transitional age youth served by MHSA with severe mental illness and who are homeless or at risk of homelessness for a total of \$220,393. The second request is to fund a family and youth involvement team of 6 staff who will serve as peer parents and youth development mentors (\$434,468).

We are inviting and encouraging all stakeholders to provide written comments on the budget plan at the following email address: prop63@sfph.org. The 30 day public comment process will end on June 30, 2007.

Mental Health Services Act
Growth Funds Planning

Original Allocation FY07-08
New Allocation FY07-08
Growth Funds FY07-08

5,702,905
7,995,700
2,292,795

Services	Agency	Age Group	Amount	%	
Full Service Partnership	Hyde Street Comm.	Adult	367,608	16%	continuation of added FSP services in FY06-07
Full Service Partnership	UCSF Citywide Case Management	Adult	367,608	16%	continuation of added FSP services in FY06-08
Housing Service Partnership	Housing and Urban Health	Adult	183,804	8%	continuation of housing for added FSPs in FY06-07
CSS Housing	Housing and Urban Health	AOA	123,096	5%	additional housing units
CSS Housing	Larkin Street Youth Program	TAY	97,297	4%	additional housing units
Trauma & Violence Recovery	Urban Services-YMCA	CYF	120,000	5%	continuation of added trauma & violence recovery services in FY06-07
Peer Based Center	San Francisco Study Center	Adult	130,000	6%	continuation of added peer based center in FY06-08
Training/Support for Peer Staff	Mental Health Assoc. of SF		50,000	2%	continuation of services started in FY06-07
Total Contracts			1,439,413	63%	

Civil Service Programs	FTEs	
Family and Youth Involvement Team	6.00	434,468 19%
Total Civil Service Programs	6.00	434,468 19%

Civil Service Personnel	FTEs	
1424-Administrative Assistant	0.50	31,748 1%
		increase from half-time to fulltime (peer hiring)
9924-Public Health Aide	3.00	129,203 6%
		peer employees who will assist in the implementation and coordination of MHSA activities
Total Civil Service Personnel	3.50	257,963 11%
		annualization of FY06-07 positions that were originally budgeted for 9 months
		418,914 18%

TOTAL EXPENDITURE PLAN FOR FY07-08 GROWTH FUNDS

2,292,795 100%



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6:30 – 8:30 PM

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PLEASE NOTE CHANGE OF LOCATION

Department of Public Health
101 Grove Street
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6:30 p.m.

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NOTICE OF PUBLIC HEARING PROPOSED REDUCTIONS IN HEALTH SERVICES
FISCAL YEAR 2007-2008

The San Francisco Board of Supervisors will conduct a Beilenson Hearing pursuant to Section 1442.5 of the California Health and Safety Code (Beilenson Act) on the elimination and/or reduction of health care services to indigents provided by the City and County of San Francisco for fiscal year 2007-2008. The Beilenson Hearing will be held:

TUESDAY, JUNE 19, 2007, AT 3:30 PM
LEGISLATIVE CHAMBER OF CITY HALL
#1 DR. CARLTON B. GOODLETT PLACE
SAN FRANCISCO, CALIFORNIA

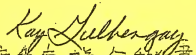
At this hearing, the Board of Supervisors of the City and County of San Francisco will consider the impact of the proposed elimination and reduction of health services on the health care needs of the county's indigents. Public testimony, both oral and written, will be accepted at this hearing.

The San Francisco Department of Public Health has prepared the attached list of proposed budget reductions that are subject to Beilenson Hearing. The list includes the elimination and reduction of health services to the county's indigents. Although California Health and Safety Code Section 1442.5 does not require notice on the elimination and reduction of mental health and substance abuse services, the Department of Public Health has included these changes in its attached list. Further information is available by telephoning the Department of Public Health at 554-2851. For information on medical services, access and eligibility, please call 206-8000.


Kay Gulbengay
Clerk of the Board

2007-2008 年度削減醫療服務公聽會

三藩市市參事會將於2007年六月十九日(星期二)
下午三時半於市政廳 (Legislative Chamber, #1 Dr. Carlton B. Goodlett
Place) 舉行關於2007-2008年度削減醫療服務提案之公聽會。
屆時敬請各界人士出席參加討論該提案對無醫藥
保健人士之影響。詳情請參閱三藩市衛生局削減
醫療服務之摘要(英語附錄)或電554-2851或
206-8000查詢。出席者可參加發言或提出書面意見。
該公聽會是按加州醫療及保健條例 Section 1442.5
之 Beilenson 規定而舉行。削減項目將包括醫療, 心理
衛生及防止濫用藥物服務。該提案將考慮完全
取消或削減以上多項服務。


市安區三三仁知政署


**AVISO DE AUDENCIA PUBLICA PARA REDUCIR EL PROSUPUESTO PARA SERVICIOS
DE SALUD IMPACTANDO AÑO FISCAL 2007-2008**

La Mesa Directiva de Supervisores de San Francisco llevara a cabo una Audencia Beilenson según la sección 1442.5 del Código de Salud y Seguridad de California (Ley Beilenson) sobre la eliminación y reducción de servicios de salud proveidos por la Ciudad y Condado de San Francisco para las persona indigentes y desamparados. Esta audencia impacta el año 2007-2008 y se llevara a cabo:

MARTES, 19 DE JUNIO, 2007, A LAS 3:30 PM
CAMARA LEGISLATIVA DE LA ALCALDÍA
#1 DR. CARLTON B. GOODLETT PLACE
SAN FRANCISCO, CALIFORNIA

Durante esta audencia, los Supervisores consideraran el impacto que tendran los propuestos cortes en el prosupuesto de reducción de servicios de salud para las persona indigentes y desamparados. En esta audencia se aceptaran testimonios publico, escritos y orales.

El Departamento de Salud Publica a preparado una lista de las propuestas reducciones al presupuesto que son sujetos a la Ley Beilenson. Esta lista incluye la eliminación y reducción de servicios medicos para las personas indigentes y desamparadas de este condado. El Departamento de Salud Publica les provee esta información como una cortesía. Para mas información, favor de hablar al Departamento de Salud Publica al (415) 554-2851. Para información sobre servicios medicos, acceso y elegibilidad, por favor llame al (415) 206-8000.


Kay Gulbengay
Clerk of the Board

DEPARTMENT OF PUBLIC HEALTH

Facility	Service Description	FY 2007-08 Change in City Positions (in FTEs)	City Position Change (Annual Number)	Expand Incr/(Decr)	Revenue Incr/(Decr)	General Fund Incr/(Decr)	Description of Change	Estimate of persons affected
SFGH Workers Compensation Clinic	Worker's Compensation Clinic	(7.05)	(8.49)	(1,311,676)	(478,420)	(633,256)	Closure of Clinic	10,500 City employees will be redirected to private providers
SFGH Inpatient Psychiatric and Emergency Services	Emergency and Inpatient psychiatric services	(14.50)	(28.80)	(222,370)	(68,717)	(133,653)	Progress Foundation, a non-profit agency, will provide a community based alternative for patients accessing SFGH's Psychiatric Emergency Services. The program is expected to be opened by the end of the year. It is expected that opening the program will reduce the use of both of SFGH's facilities. The estimated savings at SFGH is \$1,366,743 for 6 months.	Approximately 50% of the 6,719 patients seen annually in the SFGH's Psychiatric Emergency Services and 14 psychiatric inpatients per day will be seen at the community setting.
	Health at Home Public Health Nurses	(5.27)	(5.27)	(793,706)	(124,360)	(669,346)	Relocation of 5.27 of the 20.86 chronic care public health nurses.	1,010 clients visited per year
See attached list of programs that may be impacted by the reduction of adult residential and outpatient slots	Reduction of Adult Residential and Outpatient Services	1.58	2.10	(1,306,411)		(1,306,411)	Reduction of \$1,806,670 in adult residential and outpatient slots. This represents a reduction of 2.10 slots in adult residential and 1.58 slots in outpatient. A Medication Van will provide medications and medication services.	See attached list of programs that may be impacted by the reduction of adult residential and outpatient slots
SFGH Trauma Center	Intensive case management for violence injured youth and young adults	0	0	(100,000)		(100,000)	Elimination of funding	95-100 clients served annually
Positive Resource Center, 765 Market Street, 10th Flr, San Francisco, CA 94013	Emergency housing, rental subsidies, mental health/psychiatric care and support services for HIV positive LGBTQ youth.	0	0	(75,000)		(75,000)	Reduction of funding	110 clients served annually
UCSF Men of Color Project 333 California Street, Rm 15 San Francisco, CA 94113	Outreach, peer advocacy, case management, nutrition counseling and treatment advocacy	0	0	(275,000)		(275,000)	Reduction of funding	85 clients served annually
Quan Yin Healing Arts Center Valencia Street San Francisco, CA 94103	Complementary therapy services that include acupuncture treatment with licensed acupuncturists, massage therapy	0	0	(108,000)		(108,000)	Reduction of funding	260 clients are served annually by the two programs funded by the General Fund. Only one program is impacted
Tenderloin AIDS Resource Center, 187 Golden Gate Avenue San Francisco, CA 94102	Needle exchanges services for youth,	0	0	(125,000)		(125,000)	Reduction of funding	3,500 clients served annually
UCSF/AIDS Health Project Folsom Street, St. 425, Box 0897 San Francisco, CA 94133-0897	Intensive case management for methamphetamine users and peer support services.	0	0	(250,000)		(250,000)	Reduction of funding	48 clients served annually
Safehaus for juveniles: Edgewood Children's Center, 1801 Vicente St., San Francisco, CA 94116	Six day residential treatment program for sexually exploited/attracted girls under 18 years old.	0	0	(300,000)		(300,000)	Elimination of funding	An average of 3 girls per month were treated in FY 2005-07
Westside CMHS, Inc. 1153 Oak St., San Francisco, CA 94117	Outreach to youth who are at risk for community violence including providing services to the pre-arrested opportunities	0	0	(60,000)		(60,000)	Elimination of funding	60 to 80 youth served annually

DEPARTMENT OF PUBLIC HEALTH
FY 2007-08 BUDGET

Facility	Service Description	FY 2007-08 Change in City Positions (in FTEs)	City Position Change (Annual Number)	Expand Incr/(Deer)	Revenues Incr/(Deer)	General Fund Incr/(Deer)	Description of Change	Estimate of persons affected
Texas Center/Women's Community Clinic, 2108 Hayes St., S.F. CA 94117, Lyon-Harmon Women's Health Services, 1748 Market St., #201, S.F., CA 94102	Primary care medical services to uninsured women, 90% of whom are below 100% of the federal poverty level.	0	0	(200,000)		(200,000)	Reduction of funding	2,004 clients served annually
Bayview Hunter's Point Adult Day Health Center, 1250 La Salle Ave	Therapeutic recreation, personal care, and exercise assistance to the frail elderly through a professional service contract with the Bayview Hunter's Point Adult Day Health Center.	0	0	(40,000)		(40,000)	Elimination of funding	125 clients served annually
Dimension Clinic, Castro Mission Health Center, 3850 17th Street	Primary care services for the LGBTQ youth in the Castro-Mission community.	(0.37)	(0.37)	(55,892)		(55,892)	Reduction of one clinic hour per week	200 clients served annually
Drug Overdose Prevention and Education Program - Alameda County Health Coalition; Program DOPE; Address: 1440 Broadway #510, Oakland, 94612	Prevention program focusing on reducing the impact of substance use and addiction on the target population by implementing overdose prevention, recognition and response trainings with injection drug users, service providers, and criminal justice personnel.	0	0	(75,000)		(75,000)	Elimination of funding	550 clients served annually
Stimulant Treatment Outpatient Program; Address: SFCH, Building 90, Ward 83, 1001 Potrero Ave, SF 94110	Outpatient program providing group medication management and individual counseling up to once per week. Clients receive tuberculosis screening prior to admission, and physical examinations, psychological assessments and psychiatric evaluations as needed.	0	0	(200,000)		(200,000)	Elimination of funding	60 clients served annually
Outpatient Substance Abuse for Women; Agency: Mt. St. Joseph's Epiphany, Program: Adult Intensive Outpatient Program; Address: 100 Norcross Ave, SF 94118	Adult intensive outpatient program designed to help women recover from drug and alcohol abuse, address trauma and co-occurring disorders, improve family functioning via parenting skills training, increase independent living skills and reunify family, and acquisition of adequate housing and income.	0	0	(70,000)		(70,000)	Reduction in funding	21 clients served annually
Substance Abuse Enhancement for Gay Men and HIV Agency; New Leaf Program; Address: 1339 Market St, SF 94102	Mental health outpatient services designed to provide reduction of mental health and substance abuse risk and maintenance of functioning for the above- noted target population. Services include assessment/plan development, family meetings, collateral case management and consultations	0	0	(50,000)		(50,000)	Reduction in funding	15 served annually

Programs that may be impacted by (a) reduction of residential and outpatient substance abuse services associated with adding the Methadone Van and (b) reduction in the Federal Substance Abuse Treatment allocation

Agency	Modalities	Street Address	City	Zip	Current GF	Current SAPI	UOS	UDC
Asian American Recovery Services	Residential, Outpatient	1115 Mission Road	South SF	94103	667,435	1,280,198	24,788	4,060
Baker Placer	Residential	600 Townsend Street, Suite 200E	SF	94103	590,263		3,285	60
Bayview Hunters Point Foundation	Outpatient, Ancillary, Prevention,	150 Executive Park, Suite 2800	SF	94134	701,868	877,329	48,741	320
Community Awareness and Treatment Services	Methadone Maintenance	1446 Market Street	SF	94102	1,213,281	280,000	17,739	213
Curry Senior Center	Residential	315 Turk Street	SF	94110	504,281	463,350	3,575	115
Div. of Substance Abuse and Addictive Medicine - SFGH	Outpatient, Ancillary	SFGH-7M36	SF	94103	177,405	40,000	10,505	1,210
Friendship House, Inc.	Residential	333 Valencia Street, Suite 400	SF	94103	2,350,956	1,020,562	2,176	7
Haight Ashbury Free Clinics	Outpatient, Ancillary	1735 Mission Street	SF	94103	216,405	785,656	40,338	2,647
Horizons Unlimited of San Francisco	Outpatient, Prevention, Ancillary	440 Potrero Avenue	SF	94110	740,693	115,570	7,930	374
Iris Center	Outpatient	333 Potrero Street, Suite 222	SF	94103	186,710	115,570	6,300	267
Japanese Community Youth Council	Prevention	1596 Post Street	SF	94109	609,390	115,570	11,484	1,505
Jelani, Inc.	Residential	1601 Quesada Avenue	SF	94124	1,800,206	186,710	23,981	146
Larkin Street Youth Center	Prevention	1138 Sutter Street	SF	94109	1,039,212	192,984	5,963	298
Lalino Commission	Prevention	301 Grand Avenue, Suite 301	South SF	94080	395,016	400,000	14,875	995
Mission Council	Residential, Outpatient	820 Masonic Avenue	SF	94110	676,548		7,464	110
Mt. St. Joseph's Epiphany Center	Outpatient, Ancillary	100 Masonic Avenue	SF	94118			10,772	2,272
National Council Youth Services	Prevention	944 Market Street, 3rd Floor	SF	94102	639,022	112,585	10,100	443
New Leaf Services	Outpatient, Ancillary	1300 Market Street, Suite 800	SF	94102	252,779	403,780	5,000	160
Ohlloff Recovery Services	Residential	601 Sutter Street	SF	94114	400,000		2,628	80
Positive Directions Equals Change	Outpatient	2111 Jennings Street	SF	94103	204,996		4,699	927
SAGE Project	Outpatient	1385 Mission Street, Suite 300	SF	94117		376,640	350	14
St. Vincent DePaul Society	Residential	425 Fourth Street	SF	94143	53,313		72,323	2,009
UCSF Center on Deathness	Outpatient, Ancillary	3333 California Street	SF	94103	4,827,998	435,799	45,926	1,750
Walden House, Inc.	Residential	520 Townsend Street	SF	94117	414,940	778,038	304,510	515
Westside Community Mental Health Svs	Outpatient	1153 Oak Street	SF	94115	26,552		10,859	1,480
YMCA Urban Services	Outpatient, Prevention	1530 Buchanan Street	SF	94105		256,183	6,768	
Youth Leadership Institute	Prevention	246 First Street, Suite 400	SF					

Notes:
The proposed reduction in residential and outpatient substance abuse services is \$1,808,670 which is 10% of the FY 2006-07 General Fund support
The reduction in the Federal Substance Abuse Treatment allocation totals \$94,549 which is 1% of the FY 2006-07 SAPI allocation.



Gavin Newsom
Mayor

**City and County of San Francisco
Department of Public Health
Community Behavioral Health Services**

**Mental Health Services Act
Implementation Progress Report
For the period ended December 31, 2006**

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Mental Health Services Act Implementation Evaluation Report

**City and County of San Francisco
Implementation through December 31, 2006**

I. PROGRAM SERVICES IMPLEMENTATION

In March 2005, San Francisco began its implementation of the Mental Health Services Act (MHSA) with the establishment by the Mayor of a 40 member citywide taskforce. The Behavioral Health Innovations (BHI) Task Force, headed by the Deputy Director of Health, led the planning process and assisted in the development of San Francisco's three-year plan for MHSA funds by identifying and prioritizing mental health needs. The BHI Task Force was selected through a month long application process to provide representation and leadership for San Francisco's planning process. The BHI Task Force met every three weeks, with meetings in six neighborhoods throughout the City. The public was invited to observe the BHI Task Force proceedings and a public comment period was provided during the last 30 minutes of each meeting. All meetings were wheelchair accessible. Assistive Listening Devices, materials in large print and other alternative formats, American Sign Language interpreters, and other accommodations were made available upon request.

An early estimate of San Francisco's allocation was projected at \$50 million due to the high rates of mental illness and homelessness in the city. The initial planning process was done with this estimate in mind. It was a great disappointment to the BHI Task Force to learn that the actual initial funding would be only \$5.3 million. Despite the gross discrepancy between community need and designated funding allocation, the planning process continued with its objective to address only the most urgent priorities and to create services for the city's unserved and underserved population with severe mental illness.

The BHI Task Force held over 70 meetings between April and August of 2005 with consumers, their families, service providers, and other members of the community. Participants in the planning process were asked for their perspective on what was missing from mental health services in San Francisco, and what they would like to see changed. Information collected during the planning process, including position papers, provider surveys, results of peer-to-peer interviews, penetration analyses, transcripts and summaries of meetings, and usage analyses were submitted to the BHI Task Force for consideration and incorporation into the final plan. The Three Year County Plan was submitted to the Department of Mental Health in November 2005 and the plan was approved by the state in March 2006.

To initiate MHSA-funded services in the community, a Request for Proposals (RFP) was released in May 2006 for full service partnerships and general system development activities. San Francisco received nine proposals for full service partnerships and nineteen proposals for general system development activities.

San Francisco was committed to having consumer and community member participation in the selection of agencies to be funded by MHSA. To hold true to this commitment, we conducted a consumer and community member orientation to the Request for Proposal (RFP) review process. This orientation provided education about the RFP process for development and evaluation for the review panels, and enabled CBHS to accept reviewer application from informed consumers and community members. About fifty people came to the orientation and as a result, approximately one-third of the various review panels for each MHSA funded service were composed of consumers and/or community members. The technical panel reviews were conducted between July 10 – 28, 2006 and contractors were selected in August 2006. The Health Commission hearing was conducted in September and contracts were drafted for service start date in October 2006.

In general, implementation of MHSA is proceeding according to plan. There are several services that we decided to award to more than one agency for reasons outlined in the full service partnership and general system development implementation sections.

A.i County Implementation Activities by Service Category

Full Service Partnerships, Outreach and Engagement:

The County funded two full service partnerships (FSP) for children, youth and family services, two for transitional age youth services, three for adults and one for older adults.

The budgeted amount for Children Youth and Family (CYF) FSPs was equally divided between the Human Services Agency and the Department of Public Health. The Human Services Agency released a request for proposal for their allocated MHSA FSP budget, which was eventually awarded to a contracted agency to leverage SB 163 funding. Family Mosaic Project, which is a DPH civil service clinic, is the other CYF FSP. Similarly, the transitional age youth FSPs were equally allocated between DPH and a contracted provider.

The County had planned on awarding \$367,608 to an adult full service partnership (FSP). However, after reviewing the adult FSP proposals, the technical review panel recommended funding the top three agencies, which scored within half a percentage point of each other. The additional agencies were funded using the prior fiscal year's (FY05/06) three month Community Services and Support budget on a one-time basis. Renewal of their services will be contingent on availability of growth funds and service performance. In the end, we funded a total of \$1,102,824 for all three adult full service partnership programs, each of which had different target populations: homeless, criminal justice, and the Tenderloin neighborhood. We did not fund outreach and engagement separately as most of our providers integrate these services in their treatment, rehabilitative, social, and life skills setting objectives.

Civil Service FSP programs:

We funded two civil service FSP programs: Family Mosaic Project for the children, youth, and family population, and a newly created Community Behavioral Health Services Transitional Age

Youth (CBHS-TAY) Program. Both programs encountered administrative delays in getting the civil service positions approved and posted. Moreover, the clinical director of Family Mosaic Program, who was assigned to lead the implementation of MHSA, resigned and was not replaced for several months. CBHS-TAY had further hurdles in locating a clinical and administrative space and setting up protocols for the new program. Both these programs anticipate program service start dates in early Summer 2007.

Housing Service Partnerships (HSP):

We carved out twenty percent of the full service partnership budgets to fund permanent housing for full service partnership partners provided by our Housing Service Partner. Our ultimate goal is to get our full service partners into permanent housing. However, it has been our prior experience with the Direct Access to Housing Program that successful placement takes time. It was decided that the optimal process to provide urgently needed housing with the goal of ultimate permanent units was to house partners in stabilization units while permanent housing documentation (e.g., Social Security card, California ID, Birth Certificate) is being secured and while waiting for partner background checks to be completed and for permanent housing units to become available. This was especially true for a senior housing building that has been identified as a potential permanent housing locale, but is currently being renovated. This building is scheduled to become available in late March 2007. The HSP has successfully filled the stabilization units, and the process of moving FSP partners into permanent housing has begun.

General System Development

We anticipate that the General System Development programs will improve our overall mental health system by covering gaps that were identified during the community planning process. The general system development services that were funded addressed the following areas: the integration of behavioral health services into primary care; violence and trauma recovery; peer-based centers; residential treatment; vocational rehabilitation; and services to increase capacity to provide culturally appropriate services. The majority of these services was included in the request for proposals and was subject to review and approval. Although we initially intended to fund one agency for each service, in the end, we funded more than one agency for some services due to various factors. As with the full service partnerships, we did not fund outreach and engagement separately, as most of our providers integrate these services in their treatment, rehabilitative, social, and life skills setting objectives.

Integration of Behavioral Health Services into Primary Care:

The integration of Behavioral Health Services into Primary Care will make mental health more accessible within the community by facilitating access to mental health services for people receiving primary medical care; aiding in early identification of mental illness among children especially those with co-occurring autism; and providing psychiatric services at the Youth Guidance Center at the Juvenile Hall of Justice. Due to administrative delays, no clinical staff had been hired as of December 2006. We plan to integrate these services by early Spring of 2007.

Violence and Trauma Recovery:

Community violence and trauma recovery was deemed a critical need for children, youth, and families due to the escalating community violence affecting youths in San Francisco. Two agencies were funded to address this critical area. One agency targets the Mission, and the other targets the Western Addition and Bayview neighborhoods, both of which have experienced escalating rates of gang and related forms of violence. These programs aim to connect youth to healthy and culturally appropriate support systems in an effort to end the cycle of violence that plagues these neighborhoods.

Peer Based Centers:

Peer based centers are ideal venues for potential clients because they provide a safe haven for members of the homeless population. These peer based centers are centrally located in neighborhoods where homeless people congregate, making them convenient and easily accessible. They provide low threshold and non-intrusive services, so that potential clients will feel welcome and invited to engage in services when the client is ready. After the technical review panel had made their primary recommendations for this service, we decided to fund an additional adult consumer-run self-help center because it was ranked second among the applicant agencies and is highly regarded in the mental health community for its commitment to consumer-driven services.

Residential Treatment:

The residential treatment program was designed to provide two to three beds in a substance abuse residential program for clients who are dually diagnosed with co-occurring mental health conditions and who are not eligible for Medi-Cal. This was part of our conscious effort to integrate mental health and substance abuse services.

Vocational Rehabilitation:

Two vocational rehabilitation services were funded as part of our MHSA general system development activities. For too long our mental health care providers have operated as if meaningful employment was not a realistic option for severely disturbed clients. Our two providers in this field have extensive experience providing real work opportunities to mental health clients, and the specialized program services they will offer with MHSA funding will help the clients served and the system as a whole. It was our plan to leverage MHSA funding with funds from the State Department of Rehabilitation, but due to funding constraints, this plan did not materialize.

Services to Increase Capacity for Cultural Competence:

Our MHSA program which is funded to increase capacity for cultural competence focuses on youth in the Asian/Pacific Islander community, a population which historically underutilizes mental health services. This program is making special efforts to reach LGBTQ youth within the API community, a population that was identified as underserved by our community planning process.

A.ii Major Implementation Challenges:

Several administrative and programmatic issues, which came to light during the early stages of implementation, have contributed to delays in program start up.

Hiring Process:

We had requested for seven administrative positions to carry out the goals and objectives of MHSA. Although the plan was approved in March 2006, the positions could not be posted until the start of the new fiscal year in July 2006 when these positions were officially approved through the annual salary ordinance. The table below shows the hiring status of the MHSA requested positions:

Position	Date Hired
MHSA Coordinator	August 2006
Assistant Clinical Director, Adult Services	October 2006
Assistant Clinical Director, CYF Services	October 2006
Epidemiologist Evaluator	October 2006
Contracts Analyst	To be hired
Billing Assistant	To be hired
Administrative Assistant	January 2007

With the hiring of the administrative positions, we were able to begin to address the various elements of the implementation process: contracting, accounting, billing, developing program policies, protocols and processes, and building collaborative partnerships with MHSA funded agencies.

We also have requested for 9.9 full time equivalent staff within the two civil service full service partnerships and the behavioral health integration with primary care program. These positions were subject to the same budgetary requirements and restrictions as the administrative positions mentioned above. As of December 2006, none of the clinical positions were hired. Within CBHS, we have created 6 consumer/family member Peer Implementation Specialist positions especially focused on MHSA implementation. We anticipate that the people in these positions will work in different components of the MHSA implementation process, depending on their interests and the needs of the program. In addition to working with programs, we anticipate that these MHSA Implementation Specialists will use their personal experiences and expertise to advise the team on priorities and directions that are most supportive of client recovery.

With guidance from our HR department, we have also strongly encouraged that hiring interviews both within CBHS and our contractors incorporate questions about applicants' personal and familial experiences within the mental health care system as a desired qualification for MHSA-funded positions.

Contractual Process:

The contracting process proceeded more slowly than we had anticipated for a number of reasons. First, the Contracts Unit had several employee turnovers in the last fiscal year. These positions were not immediately replaced, which left them short-handed to handle contract renewals and

new contracts, which included all MHSA funded agencies. In addition, MHSA funded agencies were awarded in three segments (start up, ramp up services, and full services) to allow the agencies to get the needed infrastructure in place, outreach within their targeted population to search for potential clients, and begin engaging enrolled or identified potential clients. The added burden on structuring the contract documents to accommodate this level of funding required a lot of agency interaction and revisions to contractual budget documents.

Financial Accounting Process:

The staggered funding of MHSA was a challenge for our financial accounting unit. As of December 2006, all revenues received were combined in one account and did not have accompanying expense appropriations. This created a problem in that, as with any government accounting system, encumbrances could not be processed without appropriations in place. Secondly, the receipts were for four different pots of funding – one time, IT infrastructure, and for fiscal years 2005-2006 and 2006-2007. These revenues had to be reallocated and accounted for separately for ease in financial reporting. Lastly, each fiscal year account had to be further broken down into the service components by age group to replicate the Exhibit 6 reporting format to the State.

Billing Process:

The data collection report requirements and the new MHSA mode 60 and associated service function codes added to performance delays. The County billing system was designed primarily for Medi-Cal billing. The billing codes therefore are tied to Medi-Cal reimbursable services, which do not include mode 60. Moreover, some of the MHSA funded agencies were new to the county billing system and had to be authorized, registered, assigned unique organizational identification numbers, and trained.

Because the county's billing system is not able to accommodate data on an aggregate level, we had to find ways for the agencies to capture and report client encounters and unduplicated client counts for services that do not perform individual case management. Added to this was an initial misinterpretation that all MHSA clients would be required to have a Client and Services Information (CSI) reported to the State.

FSP Data Collection:

The delayed rollout of the State's web-based Data Collection and Reporting (DCR) system has presented challenges to our operations. Originally, the DCR system was anticipated to be available in December. With the continued delays, we have created procedures for gathering required data on hard-copy paper forms and hand-validating the forms. When the DCR system is available to us, we will need to allocate staff time to enter in the backlog of paper forms.

B. Key Transformational Activities

Throughout the planning and implementation of MHSA, San Francisco has remained committed to the five fundamental elements of MHSA: community collaboration, cultural competence, client/family driven mental health system, wellness/recovery/resiliency focus, and integrated services for clients and families. These five fundamental elements were explicitly requested to

be integrated in the milieu of services from prospective providers in the RFP and are explained in more detail in the Full Service Partnership Implementation, General System Development Implementation, and Stakeholder Involvement sections of this report.

C. Implementation of Full Service Partnerships:

As of December 31, 2006, San Francisco had authorized ten adults and eighteen in the children, youth and family age group to receive full service partnership services. As of May 1, 2007, 172 partners have been authorized.

Wellness/Recovery/Resiliency Focus:

A wellness-focused and recovery based model of service provision is one of the highest priorities for San Francisco's MHS program. To help us understand the implications of such a model, CBHS MHS administrators and Full Service Partnership (FSP) contract program providers arranged to attend immersion training at The Village, the Long Beach-based program that has pioneered a recovery-focused community psychology approach to treatment of severely impaired clients. The three-day immersion training occurred in January 2007, after the time span for this report.

Adapting a recovery model orientation, as opposed to a medical model treatment philosophy, has required us to implement significant changes in our organizational cultures. CBHS and our contracted providers have had to shift the focus of work from client impairment to client goals and functioning, including the goal of training clients for meaningful vocational options. One of our FSP providers indicated that even the shift in language, from "client" to "partner" is not one that is easily made, as it calls into question both the "expert provider" status of the staff case manager/ clinician on the one hand, and the "dependency" and "incapacity" of the person receiving services, on the other.

Full Service partnerships are planning on using a variety of approaches to provide wellness and recovery focused services, Full Service partnerships are planning on using a variety of approaches. Many approaches require staff and administrative training. Programs have contracted for, and participated in trainings on wraparound models, strength-based approaches, and various evidence-based practices (EBPs), in addition to the Village Immersion training. The providers anticipate that some elements of the EBPs may have to be modified to accommodate FSP clients, many of whom have long histories of homelessness, little education and training, inconsistent employment histories, and multiple diagnoses, including psychiatric syndromes, substance abuse and dependency, and medical and/or cognitive impairments. Additional training on the recovery model focused on FSP providers and across the broader system is a priority.

A key strategy for many FSPs to infuse a recovery orientation within their programs is to recruit and hire staff and peer volunteers who had experienced some of the same difficulties as the projected client populations, and who are themselves in recovery. Recruiting, hiring, and retaining such staff has proven to be a challenge for many programs during the startup phase.

Full Service partnerships anticipate that MHSA's flexible funding mechanisms will support a wellness/recovery focused model of care. For example, one program leveraged resources from the local newspaper's Season of Sharing (SOS) charitable campaign, which publishes vignettes of people needing financial, moral, or spiritual support during the December holiday season. The provider was able to supplement SOS funds, which were used for a housing deposit, with MHSA flexible funds to purchase a client a refrigerator and various other appliances so he could move into his own apartment.

Client and Family Driven Care

Providing client and family-driven care requires changes in individual treatment relationships and in the larger systems within which these treatment relationships occur. Recovery-focused treatment for individuals implies that agencies must form individualized plans of care that are driven by client goals, as opposed to staff's ideas of what the client may want or need.

To support the provision of client driven treatment of individuals, some of our FSP programs are training staff in practices such as creating WRAP plans with clients, or implementing the Wraparound philosophy. Some agencies, especially those that focus on providing services to children, are very familiar with this approach. One of our Child FSPs, for example, is using MHSA funds to supplement SB163 monies, which are aimed at "stepping children down" from group homes into family like settings. The wraparound philosophy used by this agency ascertains client needs and family resources, and forms plans of care that take these into account.

Some FSP agencies are working to move beyond individual client driven treatment and alter their organizational culture by trying to incorporate client suggestions into the day-to-day operation of their agency. To promote client voices into the operation of their agencies, many FSPs are planning to implement procedures to gather feedback about program operations from clients. These include such strategies as periodic formal evaluation surveys, anonymous suggestion boxes, and daily community check-ins. Programs that participate in mandated quality improvement satisfaction surveys have indicated that they hope to use results from those surveys as a way to incorporate client feedback into their program operations.

Feedback from clients has resulted in some modifications of program designs, such as altering program schedules or offering vegetarian options for lunches. Several programs are considering, or have implemented procedures to create client advisory boards, or to incorporate client members into existing steering committees.

Community Collaboration/Integrated Services

Our FSP providers are committed to meeting clients where they are and creating service plans that provide "whatever it takes" to help them achieve their goals, including the central goals of housing and vocational opportunities.

As part of the implementation of MHSA, CBHS crafted an MOU with our Department's Housing and Urban Health unit to provide access to housing units for MHSA clients who are served by FSPs. Although it is clear that the number of housing units available will not meet our anticipated needs, we hope to allocate more monies in the future as funding becomes available. Our plan allocates some housing units for short term stabilization purposes and other units as

permanent housing. We will continually assess the proportions of stabilization versus permanent housing units as services are implemented.

One part of community collaboration involves working with agencies to facilitate referrals for services to otherwise unserved or underserved clients. Most of our FSPs have formed working relationships with the Homeless Outreach Team, Project Homeless Connect, the county hospital, and the county Sobering Center (a facility for chronic inebriates), both to get referrals and to facilitate continuity of follow-up care.

One of our adult FSPs specializes in providing services to clients who have been, or are about to be, released from jail. This program has established positive collaborative relationships with Jail Psychiatric Services, the Sheriff's Department, the Public Defender and District Attorney's office, and the Adult Probation department. One of our children's FSPs, which functions as the SB163 provider, works closely with the county's Human Services Agency and the Juvenile Probation department, to serve children who can "step down" from residential placements.

In addition to fostering collaborative relationships with potential referring agencies, FSPs are collaborating with agencies that provide specialized services such as education, vocational training, and job placement. Forming collaborative relationships with new agencies always presents challenges as details of procedures are ironed out. Other community resources for FSPs are 12-step programs such as AA and NA, which San Francisco is fortunate to have in abundance. Prior to MHSA funding, San Francisco has been working to integrate our mental health and substance abuse services in the process of becoming Community Behavioral Health Services. Integration activities have encouraged mental providers to partner with substance abuse providers. The partnerships have helped prepare FSPs to provide integrated mental health and substance abuse services to clients.

Some FSPs have also planned to connect clients with other community resources, taking advantage of San Francisco's rich cultural landscape. Our children's FSP provider, for example, has had success connecting clients to volunteer jobs at a local animal shelter, the YMCA, and a local circus arts school.

Cultural Competence

San Francisco is one of the most culturally diverse cities in the world, and as such, we have given a great deal of thought to providing services in culturally competent ways. In addition to ethnic and racial cultures, we also believe that cultural competence is critical to reaching and serving groups such as those defined by sexual orientation, economic status, language, dialect, and history of oppression and marginalization.

As required by the RFP, our Full Service partnerships have all endorsed the position that a key component of cultural competence is staff diversity. Staff who are ethnically and linguistically diverse are critical to outreach and to serving clients. In addition, FSPs have made strong efforts to hire staff who are familiar with cultural issues in the groups they want to serve, such as formerly homeless people, members of sexual minorities, and ex-offenders. These staff members not only help provide access to the communities they have been part of, but they also have key roles in helping FSPs understand and meet the needs of their clients.

D. Implementation of General System Development (GSD) Programs

As of December 31, 2006, we have served 117 children, 14 transitional age youths, and 73 adults across all our general system development funded programs. About 440 are being served as of March 31, 2007.

Wellness/Recovery/Resiliency Focus

Our GSD funded providers are all programs within community based agencies. Some of these programs are housed in agencies that have long standing relationships with San Francisco's diverse communities. Most of the GSD-funded providers have not had a history or organizational identity of exclusively providing mental health services. Instead, they have often worked as community advocacy groups, have their roots in the consumer self-help movement, or are embedded in community social service organizations or the public school system. Some of their mission statements explicitly stress the primary importance of building community by advocating policies and providing services that foster client self-sufficiency. This history has meant that, for most of these agencies, a wellness, resiliency-focused, strength-based model is consistent with their organization's original mission.

In other words, rather being primarily a mental health provider who has to "unlearn" some aspects of a "medical model" approach, many of the GSD providers are very familiar with wellness and recovery-focused approaches. As agencies, they have typically emphasized engaging with client strengths, as opposed to decreasing client impairments. Most of these programs have very low thresholds to provide services, and do not, for example, require prospective clients to complete lots of paperwork, or undergo psychological assessments before being eligible for services, even though the majority of their clients have mental health or dual diagnoses. Providers who have these histories are familiar with providing services within a harm-reduction approach which provide encouragement, hope, and support, even in the face of stresses and setbacks.

Many of our GSD providers have long histories of hiring staff who are in recovery, or who have deep relationships with the communities served by their agencies. For example, one of our providers is using MHSA funding to offer residential treatment to dually diagnosed persons (i.e., clients with severe mental health problems who also have substance dependence) who are not Medi-Cal eligible. This program routinely hires staff who have overcome addiction. Indeed, exposing new clients to these peers is an essential component of the agency's services, in that it provides hope and inspiration to the newly admitted client. Another one of our providers is focused on helping respond to, and ameliorate the effects of, gang violence in the Mission, San Francisco's predominately Latino neighborhood. This provider believes they would not even be able to gain entry to the community to perform their tasks unless they were represented by staff who were formerly associated with gang culture themselves. Recruiting, hiring, and retaining staff with such specialized qualifications can be very challenging. But it is worthwhile in that these staff people are able to teach prospective clients about resiliency by being living examples of recovery at work.

Two of our GSD providers focus especially in vocational rehabilitation. By focusing on meaningful employment-related outcomes, these providers strongly emphasize the wellness-focus of community reintegration.

One of our Supportive Services for Housing programs is targeted at transitional aged youth, a population which is tremendously at risk for homelessness. Many of these youth have aged out of the foster care system and are coping with the tremendous loss of support and resources. Because housing slots are not directly available to clients through this program, this agency is using these MHSA monies to help youth maintain housing by facilitating fiscal responsibility, promoting employment skills, and teaching household maintenance skills. This agency also administers our Transitional Residential Housing units which will make 10 housing units available, along with case management services to homeless youth. Our other SSH program targets seniors and their unique needs in maintaining housing. This program will hire a psychiatric nurse practitioner to visit Single Room Occupancy hotels in San Francisco's Tenderloin neighborhood and link seniors with mental health, physical, medical, emotional, social, and substance abuse support services.

The four peer based centers we have funded are targeted toward transitional aged youth, adults (2 centers), and older adults. An additional school-based "Wellness Center" was funded to expand services targeting children and youth. These centers add an important element into San Francisco's system of care. Such centers allow isolated clients to engage with services that are offered with a very low threshold, avoiding admitting procedures that may frighten clients who are fearful of professional service providers. These programs also provide a venue to engage clients in more personalized services as they become more comfortable and trusting of staff. One of the adult peer based center was funded because of its reputation in the mental health community as a peer run self-help center. With MHSA funding, this agency plans to extend its hours of operation during the week as well as expand its services to seven days.

Many of our GSD providers have a strong focus on helping clients connect with, and benefit from the support of the community, whether it is a community composed of the group of clients inside an agency or a school, composed of members in an ethnic or socio-cultural group, or the larger community. By focusing on social support and integration with the community, these providers will help clients combat the isolation and stigma associated with mental health problems.

Providers anticipate possible difficulties of a community integration approach. Staff, peers, and clients who are in recovery can be threatened by exposure to triggers, particularly if their hold on their own recovery is tenuous. Former gang members may also risk re-traumatization by exposing themselves to violence-related trauma in the community, and people with symptoms of mental illness may face discrimination by attempting to make community connections. Some of our providers are preparing for these possibilities by establishing training and self-care programs for their staff, including debriefing, supervision, and healing circles.

Client and Family Driven Care

Most of our GSD providers have long-standing histories working to advocate for clients and thus have much experience soliciting input and feedback from their clients. Many of these providers

have regular community meetings which invite client input. One provider has hired an activities coordinator with its MHSA-funding – this coordinator has established a "Voice of the Community" group, which is explicitly focused on gathering client suggestions for activities. This group not only provides a forum for client suggestions and input, but also serves as a means to reach out to isolated clients and recruit them into active roles in the community.

Agencies indicate that they are gathering (or planning to gather) client feedback using such means as self developed multi-lingual needs assessments and/or suggestion boxes. One program uses an external evaluation firm, so that feedback is gathered systematically and impartially. Other programs are planning to use focus groups to gather client feedback. Some providers even used client-driven processes when planning their response to the County's MHSA RFP. These agency's MHSA programs are quintessentially client driven, in that they were formed in response to clients' insights about their own and their community's needs.

It is important that feedback is responded to, so that clients have the experience that their feedback is valued, not ignored. Some client suggestions are easily and quickly responded to – for example, one of our providers of vocational rehabilitation varies the pace and topics of their trainings depending on client feedback. Others providers have altered schedules, or incorporated gender- or language-specific services in response to client feedback. Some of the GSD agencies already have procedures in place for routing suggestions to appropriate departments and publishing both the suggestions and the actions taken in response to them.

Community Collaboration / Integrated Services

Many of our GSD providers are already part of, or have joined with, collaborative networks with other CBOs to get referrals and to provide specialized services to clients. These specialized services address many client needs, including vocational training and placement, substance abuse and mental health problems, holistic health and primary care services, senior services, dental care, spiritual needs, and food and shelter programs. We also hold monthly meetings with all our GSD providers to promote collaboration and information sharing between programs.

Several GSD providers that work with clients who have criminal justice involvement have collaborative relationships with community initiatives targeted to helping ex-offenders. One such community initiative is the Public Defender's Clean Slate program, which helps ex-offenders by criminal record expungement. Our GSD program that is targeted toward ameliorating the effects of gang violence collaborates with a provider that can remove gang tattoos for clients who want to move away from their identities as gang members. Our GSD provider that is a self-help peer-led organization, helps advocate for participants who have had difficulty participating in community social services due to their emotional problems.

Two of our GSD providers operate within public schools. These programs help create integrated services by collaborating with school Wellness Centers and with after school tutoring and mentoring programs, such as the Beacon Initiative and the Boys and Girls Club.

Many GSD providers have strong roots in their ethnic communities and rely on that community's resources to help combat client isolation. One agency has a strong relationships with spiritual leaders in the Latino community, and has convened drumming circles and a "Women's

Ceremonial” to promote dialog and to honor the role of Latina and Native American women as peace keepers in the community. One of our youth providers has been conducting an outreach campaign in the Asian Pacific Islander community to decrease the stigma associated with mental illness in that community and to connect with young people in need. Both of these agencies incorporate a focus on new immigrant populations to help these families cope with cultural differences and the difficulties youth and parents have maintaining positive relationships while weathering immigration-related traumas.

Cultural Competence

San Francisco is one of the most culturally diverse cities in the country. In addition to ethnic and racial cultures, we also believe that cultural competence is critical to reaching and serving groups such as those defined by sexual orientation, economic status, language, dialect, and history of oppression and marginalization.

Several of our GSD providers target their services exclusively toward particular ethnic communities, such as the Latino and API communities. These organizations have tremendous cultural and linguistic resources at their disposal and are available to be resources to other organizations. Our API program has formed a special Wellness Center targeting queer youth in the API community, a population that was identified as underserved by our community planning process. Because many youth find community affiliations on the internet, this program has performed innovative online outreach, including the use of youth-oriented social networking websites.

Many GSD providers also indicated that part of their approach to cultural competence consists of ensuring that their environment celebrates the cultural heritage of those whom they wish to serve. For example, they ensure that their facilities display ethnic art, and that they celebrate ethnic holidays with the help of clients who have that ethnic background.

Our MHSA program which is specifically funded to increase capacity for cultural competence focuses on youth in the Asian/Pacific Islander community, a population which historically underutilizes mental health services.

Our residential treatment GSD provider also indicated that it has an ongoing relationship with a translation service that provides them with the capacity to speak 150 languages. Several providers also mentioned the need to consider low client literacy and ensure that their materials have a realistic reading level and are illustrated, whenever possible. Having materials available in alternate formats (e.g., audio, Braille, sign language) was also mentioned as a cultural competence strategy by a number of providers.

II. EFFORTS TO ADDRESS DISPARITIES

A. Current Efforts and Strategies

Many different factors contribute to disparities in access to and quality of care. Our County's response to disparities include addressing outreach, providing a welcoming environment for clients, ensuring that client perspectives are included in policy and program planning, and addressing fragmentation of services.

Fragmentation of services. One important contributor to disparities is the fragmentation of services to high need clients. One promise of the MHSA is that it can help address the tendency of services to exist within their own limited "silos." The fragmentation of the social services system is an understandable consequence of many factors, but fragmentation can have devastating effects on clients, especially those whose needs encompass services from many different, disconnected systems. If people are homeless, medically ill, and have both mental and substance abusing problems, it is a daunting task to meet any one of these needs, let alone all of them. Such clients are rarely in a position to advocate to get the services to which they are entitled because they become frustrated, stressed, and discouraged.

Addressing fragmentation requires collaboration across agencies and systems. Within the County, CBHS has tried to address the service system's fragmentation by promoting an ideology of integration in which "Any Door is the Right Door." Meeting people where they are and providing services they need requires the system to address those factors that restrict service availability. San Francisco's MHSA response is an attempt to use the Act's flexible funding to bridge service gaps and help clients achieve meaningful goals and craft an identity as a contributing member of society.

Homelessness is an enormously important problem in San Francisco, and many homeless people have co-occurring emotional and substance use problems. In addition, the housing market in San Francisco is extremely limited, especially for lower income people. The homelessness problem is being addressed at many levels of the public and private sectors. Many initiatives have been created to target homelessness, including Mayor Gavin Newsom's Project Homeless Connect, which uses community volunteers to find and connect homeless people to services. The Homeless Outreach Team is a DPH initiative which provides access to housing, addresses crises, and facilitates continuity of care while reaching out to chronically homeless people. Many of our MHSA-funded programs participate in Project Homeless Connect events.

With many different departmental responses to homelessness come the hazards of service fragmentation. MHSA one-time funding has provided a means to coordinate services and collect data to help evaluate our systems. These funds have helped create and support a Coordinated Case Management system, which is a web-based database that integrates encounter-level data from many different public and private agencies serving homeless people. We anticipate these data will help us evaluate the operation of our MHSA program.

MHSA one-time funding is also supporting the expansion of our Shared Youth Database, a unique database application that merges service and encounter level data from our Mental Health

system, the Child Welfare system, and Juvenile Probation. MHSA one-time funding will be allocated to incorporate data from the San Francisco Unified School District and DPH Substance Abuse Treatment Services. These data help case managers assess young people's needs holistically, and also will help us evaluate how well our system is meeting the needs of young people who have multi-system involvement.

B. Outreach

San Francisco was committed to having consumer participation in the selection of agencies to be funded by MHSA. To hold true to this commitment, we conducted a consumer and community member orientation of the Request for Proposal (RFP) review process. This orientation served to educate them about the process and to recruit members for the review panel. Outreach included flyers, Internet, email, and in-person engagement efforts (in English, Spanish and Cantonese) and took into account the distinctive culture of each of San Francisco's neighborhoods.

About fifty people came to the orientation and as a result, approximately one-third of the various review panels for each MHSA funded service was composed of consumers and/or community members.

Our providers all endorse the position that a key component of outreach to underserved groups is staff ethnic and linguistic diversity. In addition, programs have made strong efforts to hire staff who are familiar with cultural issues in the groups they want to serve, such as formerly homeless people, members of sexual minorities, and ex-offenders. These staff members not only help provide access to the communities they have been part of, but they also have key roles in helping providers understand, and meet the needs of their clients.

Several of our GSD providers target their services exclusively toward particular ethnic communities, such as the Latino and API communities. These organizations have roots inside those communities and rely upon their networks to recruit and hire qualified individuals.

Many providers also indicated that part of their outreach strategy is to ensure that clients from underserved groups feel welcome in their program. CBHS requires that all contracted and civil service programs have policies in place to ensure that they offer a welcoming environment. One strategy for accomplishing this goal includes ensuring that printed materials are available in multiple languages and alternate formats. In addition, several programs indicated that they ensure the physical environment celebrates the cultural heritage of those whom they wish to serve. For example, many programs ensure that their facilities display ethnic art, and that they celebrate ethnic holidays with the help of clients who have the ethnic background.

Our MHSA program which is funded to increase capacity for cultural competence focuses on youth in the Asian/Pacific Islander community, a population which historically underutilizes mental health services. This program is making special efforts to reach LGBTQ youth within the API community, a population that was identified as underserved by our community planning process.

Our residential treatment GSD provider also indicated that it has an ongoing relationship with a translation service that provides them with the capacity to speak 150 languages. Several providers also mentioned the need to consider low client literacy and ensure that their materials have a realistic reading level and are illustrated, whenever possible. Having materials available in alternate formats (e.g., audio, Braille, sign language) was also mentioned as a cultural competence strategy by some providers.

Several of our GSD providers help potential clients feel welcome by making their services available with a very low threshold. Such programs, which have long experience in the community, find that many impaired clients may be frightened away from their programs if staff request information from them. These clients may not feel safe unless they can just show up and be left alone for a time. One participant, for example, came to a program and sat in the same seat every day from 7 am to 7 pm without interacting with anyone. This program's MHSA-funded outreach coordinator was able to approach this client and ultimately recruit him to be part of their "Voice of the Community" group, and to participate in additional program activities.

C. Equal Opportunities for Employment

Within CBHS, we have created consumer/family member positions especially focused on MHSA implementation. We anticipate that the people in these positions will work in different components of the MHSA implementation process, depending on their interests and the needs of the program. In addition to working with programs, we anticipate that peer Implementation Specialists will be able to use their experiences and expertise to advise the team on priorities and directions that are most supportive of client recovery.

For our MHSA-funded programs, all providers targeted underserved groups and are expected to ensure that their program staffing contains sufficient linguistic and cultural diversity to enable them to do so. We anticipate that data about program ethnic diversity and linguistic capacity will be part of our evaluation of program services, as will data about the racial and ethnic composition of programs' client population.

D. Native American and/or Tribal Communities

Our MHSA RFP identified Native Americans as an underserved population. Unfortunately, no proposals that specifically targeted this group for services were submitted in response to the RFP that specifically targeted this group for services. In spite of this, one local agency that serves this community has been actively participating in the implementation process by hosting community forums conducted by the MHSA Advisory Board as well as meetings convened by the Mental Health Board. Moreover, one of our GSD provider that targets the Latino community indicated that "Women's Ceremonial" that they convened in October 2006 in honor of Indigenous People's Week included Latina and Native American women. The Native American community also had on-going representation in both the initial planning process and the MHSA Advisory Board. We will continue to perform outreach efforts to ensure that the Native American community is targeted in future applications.

E. Policy and System Improvements Specific to Reducing Disparities

With guidance from our HR department, we have also strongly encouraged that hiring interviews both within CBHS and our contractors incorporate questions about applicant's personal and familial experiences within the mental health care system, and that job announcements indicate that having such experience is a desired qualification for MHSA-funded positions.

We also ensure that all community meetings are held at sites with wheelchair accessibility and that other alternative formats and languages, American Sign Language interpreters, and other accommodations are made available upon request.

III. STAKEHOLDER INVOLVEMENT

Prior to MHSA, San Francisco had already embarked on an integration process to combine both Mental Health and Substance Abuse Services under the umbrella of Community Behavioral Health Services (CBHS). The CBHS integration process embraced the principles echoed by MHSA of meeting clients where they are at in a system where "any door is the right door". The planning for the CBHS process created a welcoming and accessible system for all consumers including those with co-occurring disorders and provided a foundation for the MHSA plan.

The 40 member Behavioral Health Innovation Task Force served as the first model for citywide representation. A month long process was held to identify Task Force members who would be representative of people with mental illness who also belong in one of the diverse ethnic, cultural, socio-economic groups living in the city. This task force was further divided into sub-committees with representation and leadership from consumers, family members, homeless and housing, vocational and self-help, the criminal justice system, and all age groups (children, transitional age youth, adults and older adults) identified to be funded through MHSA. To facilitate full participation in community meetings, consumers and family members were reimbursed for transportation, food, and childcare services whenever their presence were required. Lastly, this task force and its sub-committees held over seventy (70) meetings between April and August of 2005 to ask consumers, their families, service providers, and other members of the community to identify and address gaps in mental health services in San Francisco.

We applied the same sense of purpose in the stakeholder process for the Request for Proposal (RFP). We conducted a consumer and community member orientation to educate them about the process and to recruit members for the review panel. About fifty people came to the orientation and as a result, approximately one-third of the various review panels for each MHSA funded service was composed of consumers and/or community members.

At the end of the initial planning process, all the task force members were requested to apply for membership in the new MHSA Advisory Committee. About half of the defunct task force are

now members of the MHSA Advisory Committee and additional members have been recruited to ensure diverse community representation. The MHSA Advisory Committee meets every two months, alternating between committee meetings and community forums. These meetings and forums serve as a platform to discuss the progress of the MHSA implementation and updates about further State implementation of the other components of MHSA. During the community forums, the public is invited to speak about their ideas, suggestions, or critiques of the implementation process. We hold these community forums at different locations within the city to encourage participation and to gain recognition of MHSA services within that neighborhood. So far, we have held meetings at the Bay View and Tenderloin districts, with one upcoming meeting that will be held in the Mission district.

Recognizing that the continued involvement of consumer, family members and other mental health advocacy groups would be essential to the success of MHSA, CBHS actively participates in meetings organized by the Mental Health Board and the National Association of Mental Illness (NAMI), as well as the Children and Adult Systems of Care within CBHS. Furthermore, San Francisco considers that the stakeholder process is a 360 degree process involving not just local constituents but also statewide policy holders. Consequently, MHSA management and administrative staff are regular participants of the Department of Mental Health's stakeholder meetings as well as statewide conferences, trainings, and workshops. In addition, we participate in meetings and phone conferences convened by California Mental Health Directors Association (CMHDA) and California Institute of Mental Health (CIMH).

Our commitment to stakeholder involvement extends to employment of consumers and family members. CBHS required all MHSA funded agencies to include positions within their MHSA funded services for consumers and family members. CBHS' implementation plan included hiring of an administrative assistant and six part time MHSA Implementation Specialists who have had personal experiences as mental health consumers or as family member of persons with mental illness. We engaged the Mental Health Association to assist us with the initial supervision of these new staff as our own staff attain more skills in this area, coordination of support groups for all staff hired through MHSA systemwide, and development of an informational brochure for consumers and family members. We also distribute job opening flyers from all MHSA funded agencies to all our contacts within the MHSA Advisory Committee, the Mental Health Board, the CBHS Peer Internship Program, and the Volunteer Center so that these agencies could get a wide breadth of applicants.

Knowing that employment is a crucial aspect of the recovery process, we worked closely with the CBHS Peer Internship Program to fund a Leadership Track for those peers who have graduated from the initial two year internship program. The Leadership Track will provide additional skills and training that will enable graduates to gain more meaningful employment and attain more responsible positions within the system. We also funded several training programs for both employers and employees to educate them on the wellness and recovery model, introduce them to evidence based practices, assist them with unique supervision requirements for persons with mental illness, legal and ethical considerations, and interviewing skills for both employers and employees. These trainings were coordinated with CBHS Training Division, as well as other agencies that had requested our participation or assistance in communicating their training schedules to our network.

San Francisco has had a long history of attracting diverse groups of people because of its welcoming and non-discriminatory policies. Mayor Gavin Newsom recently reaffirmed San Francisco's Sanctuary City status stating that "when certain people are targeted and denied access to vital social services, the health and safety of the entire city is compromised." It is not uncommon to have stakeholder groups comprised of persons who are unserved or underserved within various ethnic and cultural groups in addition to people identifying themselves through their sexual orientation or socio-economic and legal status. Also included in the stakeholders group are people who have been ostracized due to the stigma surrounding mental illness. It is with these various strata of stakeholder participation that we envisioned the pathway for our MHSA funded programs. These collaborative alliances will continue in the planning and implementation of the other components of MHSA as the State releases the guidelines and as they become available to all counties.

IV. PUBLIC REVIEW AND HEARING

The first draft of the San Francisco Implementation report will be previewed at the MHSA Advisory Committee community forum on Wednesday, April 25, 2007 to be held at Friendship House in the Mission District. The 30 day public comment process will commence on May 1, 2007. This same draft will be posted in the CBHS-MHSA website at <http://www.sfdph.org/Prop63/default.htm> and will also be distributed to all our mental health service provider sites by the MHSA Implementation Specialists. Public comments can either be emailed to prop63@sfdph.org, faxed to 415-255-3529 or mailed to Kevin Ledbetter, MHSA Administrative Assistant, 1380 Howard Street, 4th Floor, and San Francisco, CA 94103. For questions about the report, a dedicated phone line has been set up for people to leave messages. The number to call is (415) 252-3084. All calls will be returned within 24 hours. The public comment will end at close of business on May 30, 2007. The public hearing by the local Mental Health Board will be held at their regular monthly meeting on Tuesday, June 13, 2007.



SAN FRANCISCO MENTAL HEALTH BOARD



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UNADOPTED MINUTES

Mental Health Board
Wednesday, June 13, 2007
City Hall, Room 278
San Francisco, CA 94102

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BOARD MEMBERS PRESENT: Rebecca Turner, Ph.D. (Chair); James L. McGhee (Vice-Chair); James Shaye Keys (Secretary); Bridgett Brown; LaVaughn Kellum King; Dr. Toye Moses, Ph.D., M.P.H.; Tom Purvis; Jagruti Shukla, M.D, M.P.H; Lisa Williams; Virginia Wright.

BOARD MEMBERS ABSENT: Jeanna Eichenbaum, L.C.S.W; John Kevin Hines; Claudia Lebish.

OTHERS PRESENT: Helynn Brooke (MHB Executive Director); Ayana Baltrip-Balagas (MHB Administrator); Francis Lu, MD, SFGH; Emeric Kalman, Member of the Public; Julio Montes De Oca, Conard House; Frank Vallecillo, Sunset Mental Health-MHA-SF; Alex Kutik, Member of the Public; Joyce Rich, Member of the Public; Laura Barber, Member of the Public; Mary R. Higgins, M.R. Higgins & Associates; Kathleen Connolly, Citywide Case Management Forensics; Marven Lightner, Member of the Public; David Keck, CBHS, Member of the Public.

CALL TO ORDER

The meeting was called to order at 6:34 p.m. by Rebecca Turner, Ph.D. (Chair).

ROLL CALL

Ms. Brooke read the roll.

AGENDA CHANGES

Dr. Turner: "We're going to first vote on action item 3.2, because we have a quorum now and a board member has to leave early. Is there any public comment? Our resolution is to approve the minutes of the Board Meeting of May 9, 2007."

Item 3.0 ACTION ITEMS

3.1 Public comment relevant to Item 3.0

There was no public comment.

3.2 Resolutions.

3.2.a PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of May 9, 2007 be approved as submitted.

Minutes approved unanimously.

Item 1.0 DIRECTORS REPORT

Monthly Director's Report

June 13, 2007

1. **Successful All-Staff Meeting of CBHS Adult/Older-Adult SOC.** Over 1000 providers from contract and civil service mental health and substance abuse programs attended the CBHS All Staff Meeting of the Adult/Older Adult System-of-Care on May 9th and 10th at the Bill Graham Civic Auditorium.

The purpose of the All-Staff Meeting was to share with all CBHS providers the vision of addressing behavioral health needs in San Francisco in an integrated, seamless, and comprehensive manner. The challenge that has commanded our attention in recent years involves the provision of services to persons with mental illness and with substance abuse problems in a manner that CBHS contributes significantly towards addressing major health and human service needs in San Francisco, including addressing homelessness, community violence and other community issues. This involves partnership with other services such as primary care, court system, human service and housing agencies. Several of our milestone achievements in the recent period demonstrate that we are heading in this right direction.

Dr. Mitch Katz visited to welcome the participants at the meeting, and to thank all CBHS employees across our system for everyone's important contributions toward the wellness of the community. He emphasized the necessity of providing holistic care to the persons we serve, and that this is best done through integration of mental health, substance abuse and primary care, and the development of community partnerships.

A series of presentations and workshops ensued throughout the day, which further explored the areas discussed above. Dr. Alice Gleghorn and several community providers presented the exciting work occurring in San Francisco due to the infusion of new funds through the Mental Health Services Act. Dr. Tina Yee introduced a panel of consumers who eloquently and movingly shared stories of their recovery journeys. Edwin Batongbacal, Director of Adult/Older-Adult Systems-of-Care provided an overview of the wellness-recovery principles that guide our service-delivery. Over 20 CBHS providers presented in workshops addressing issues of community violence, integration with primary care services, work as a component of recovery,

care needs of women, welcoming practices at our programs, addressing homelessness, and self-care in the workplace.

The highlight of both days were the recognition ceremonies, during which staff and programs from throughout the system were recognized for the exemplary work they perform on a daily basis. Nominations for recognitions were made by their co-workers, supervisors and the clients they serve.

Overall, the event was a resounding success. Thank you to all who helped organize the event, and to everyone for participating!

2. **Mental Health Board Awards Reception.** The San Francisco Mental Health Board held its first gala Awards Reception on May 31, 2007 at The Arc of San Francisco. The room was filled and the balcony overflowed with awardees, friends and co-workers to celebrate Exceptional Programs and People. In attendance was Chief Heather Fong, Jeff Adache, Public Defender, Judge Mary Morgan, Judge Ballati, Judge Tsenin, Supervisor Maxwell, Executive Directors of many programs, consumers, and family members. The keynote speaker for the evening was Assemblyman Mervyn Dymally, Chair of the Health Committee for the California State Assembly. Jacqueline Horn, PhD, President of the Board of Psychology and Supervisor Sophie Maxwell made a few remarks. Belva Davis was the Mistress of Ceremony for the evening.

The Mental Health Board selected programs from five areas for these awards.

- Criminal Justice Response to Mental Illness: San Francisco Police Department, Behavioral Health Court, Jail Psychiatric Services
- Foster Care and Mental Illness: Foster Care Mental Health Services, A Home Within, Honoring Emancipated Youth (HEY), Family Mosaic, Robin Love
- Violence Prevention: The SAGE Project, Instituto Familiar de la Raza, Urban Services, YMCA, Girl's 2000 Hunters Point Family, Mission Community Response Network, Brothers Against Guns, CHALK, Larkin Street Youth Services, United Playaz, Homeless Children's Network, Supervisor Sophie Maxwell
- Healthy Workplace Awards: Richmond Area Multi-Services, Edgewood Center for Children and Families, Conard House, Iris Center, Huckleberry Youth Programs, Youth Leadership Institute, Oakes Children's Center, Curry Senior Center, The Volunteer Center
- Community Leadership Award: Mental Health Association of San Francisco

The Mental Health Board was pleased to honor so many great programs and individuals.

3. **Appointment by Governor Schwarzenegger.** CBHS Director of Cultural Competency and Client Relations, Tina Yee, Ph.D., and CBHS Medical Director of Quality Improvement, Al Gaw, MD, were recently appointed by Governor Arnold Schwarzenegger to the Advisory Committee to the California Department of Mental Health for Developing the California Strategic Plan for Suicide Prevention. *Congratulations Tina and Al!*

4. **Community Behavioral Health Services (CBHS) Integration.**

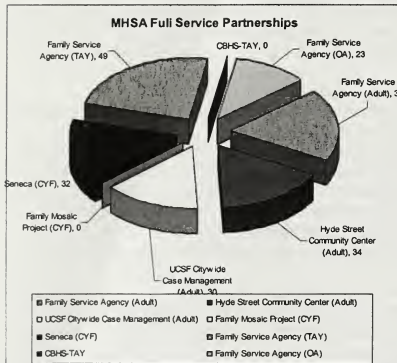
CBHS has launched a new Integration Information Line at (415) 252-3086. This phone line provides pre-recorded information on upcoming Change Agent Monthly Meetings and Leadership Trainings.

Zialogic will be arriving to conduct a quarterly consultation with CBHS on Monday, July 9th. Zialogic is scheduled to meet with CBHS Exec team and Integration committees. Zialogic will also provide a day long Leadership training with Change Agents on July 20th.

5. **Mental Health Services Act (MHSA) Update.**
COMMUNITY SERVICES AND SUPPORTS (CSS)

Full Service Partnerships (FSPs) :

207 partners have been authorized to receive full service partnership services as of close of business on June 1, 2007. The chart and table below show the age group of these partners and the agencies where they were referred to:



AGENCY	Total
Family Service Agency (Adult)	39
Hyde Street Community Center (Adult)	34
UCSF Citywide Case Management (Adult)	30
Family Mosaic Project (CYF)	0
Seneca (CYF)	32
Family Service Agency (TAY)	49
CBHS-TAY	0
Family Service Agency (OA)	23
Total	207

MHSA – Housing Service Partnerships (HSP):

Of the twenty two (22) stabilization units available for FSPs, twenty (20) are occupied through June 1, 2007. Three Adult partners have recently moved into permanent housing units.

Six Transitional Age Youth partners are in permanent housing.

General Systems Development:

The total numbers for unduplicated clients will be available for the fourth quarter on July 31, 2007. The total number of unduplicated clients served through the end of the third quarter is 673.

MHSA Implementation Progress Report :

The thirty-day public comment period on this report ended on May 31, 2007, with no comments received. The Mental Health Board will have a public hearing on June 13, 2007, after which the report will be submitted to the State on the deadline date of June 29, 2007.

Fiscal Year 2007-2008 Growth Fund Budget:

The 2007-2008 Growth Fund Budget of \$2,292,795 was posted on the DPH web site for public comment on June 1, 2007. A notice was also publicized in the San Francisco Chronicle on June 4, 2007, welcoming all stakeholders to participate in the 30-day public comment process. The growth funds were a result of unexpected additional revenues received above the anticipated 1% income tax revenue projected to be received by the State, from Californians with incomes above \$1,000,000.

WORKFORCE EDUCATION AND TRAINING:

The last Workforce Development Education and Training Committee meeting was held on June 7, 2007. The State has delayed publication of the final guidelines until the end of June or early July. The committee will reconvene to review all recommendations, to insure that they are still within the framework of the final guidelines. They will then constitute the basis of our three-year plan, to be submitted to the State for approval.

MENTAL HEALTH ASSOCIATION FOCUS GROUPS

The Mental Health Association of San Francisco will hold two separate focus groups with MHSA funded agencies to learn more about their implementation strategies, challenges and success stories and to foster ongoing collaborative relationships with community based organizations funded by MHSA. The first focus group will be with Hyde Street, one of the adult FSP program, on June 14, 2007 from 3:00 –4:00pm. The second will be conducted at Larkin Street Youth Center, funded to operate a peer based center and transitional residential housing for TAY and deliver supportive services for housing, on June 27, 2007 from 2:30 – 3:30 pm.

MHSA ADVISORY COMMITTEE MEETINGS:

The Mental Health Services Act Advisory Committee meets bi-monthly from 3-5pm, alternating

between advisory meetings and community forums. The schedule of upcoming meetings is as follows:

Thursday, June 28, 2007
Advisory Committee Meeting
1380 Howard Street
4th floor conference room

Wednesday, August 29, 2007
Community Forum
Location to be determined

Other Upcoming Events:

Safe Workplace Violence Prevention by Mike Arraj – August 31, 2007 (AM and PM sessions), Philip Burton Federal Building. Limited seating available.

To register for these trainings, please contact Norman Aleman, CBHS Training Coordinator at 415-255-3553 or email norman.aleman@sfdph.org

Past issues of the CBHS Monthly Director's Report are available at:

<http://www.dph.sf.ca.us/CBHS/default.htm> To receive this Monthly Report via e-mail, please e-mail kathleen.minioza@sfdph.org

Dr. Cabaj: "I will do a quick report, since you have the written one in front of you, so we have time to look at the other items on the agenda.

Just to highlight, we had mentioned before that there was an all adult staff meeting. We had about 1100 providers who attended the two-day meetings and it was quite successful—lots of interaction, lots of looking ahead to the future. Dr. Katz came and addressed the group and it was a very successful event. We hope to make it an annual event.

I highlighted in my report, although it was your event, the Mental Health Board's Awards Reception. It was such an outstanding evening and I wanted people to be aware of it throughout the system, and Dr. Katz was also mentioning this in his report since it was so outstanding. I was very impressed with the audience of judges and policemen, and the Public Defender; and how people who might not ordinarily be in the same room were all there together, and I thought you did an amazing job. It just reflects the strength of the Board as well as the integration of our systems with all the different forces that we work with. So thank you.

We've been honored to have two of our staff appointed to the Advisory Group on Suicide Prevention and this includes Dr. Tina Yee, who's currently our Director of Cultural Competency and Client Relations. I think you also know Dr. Yee is going to be retiring the end of this month, June 30th, and Dr. Albert Gaw, who is our Medical Director of Quality Management. Dr. Gaw retired, but came back to work for us. We are pleased that they will be honored on the state level. As an aside, Dr. Gaw just had a very good article published about Filipino American mental health services and their needs in the current issue of *Psychiatric Services*; so you might want to research that article. It's very, very good.

Our integration efforts continue. We've created a new hot line for the change agents. That's the group that is leading the charge and getting people motivated and active in integrating mental health and substance abuse.

Following, we have an update, which is the current information about the Mental Health Services Act's use of our dollars to date, including the use of the Full Service Partnerships (FSPs) and some of our other system change efforts. I won't read you all the data because it's collected here in the report, including a graph, pointing out some of the ways we distribute the patterns of service delivery, as well as the dollars.

The Workforce Development, Education and Training Taskforce has completed its work, and will be finishing their recommendations. Our group is actually in the lead in the State, and we still haven't received the official guidelines about what to do with that additional portion of Mental Health Services Act dollars money.

We'll be poised to have some ideas, and then we will incorporate what we can from the recommendations of that group with the state guidelines and maximize the ways we can use our dollars. The Mental Health Association has also been helpful, not only in getting the word out on this evening's hearing, but also bringing together focus groups to help us look at the changes that the Mental Health Services Act has done in the community. They're focusing on transitional age youth and peer based services. The feedback will be helpful for the state, which has been trying to collect more information.

As you know, we have an ongoing advisory committee, which we created to guide the work of the Mental Health Services Act as it unfolds in the city. June 30th is the Advisory Committee meeting. The meeting on Wednesday, August 29th will be open to the full community. Everyone is welcome to come. We have public comment at every other meeting, and the next one is in August.

Finally, we have an upcoming training on violence prevention in the workplace."

Dr. Turner: "Thank you. Are there any questions or comments for Dr. Cabaj?"

Dr. Cabaj: "I'll be happy to comment on what I know about budget.

Dr. Turner: "That would be great."

Dr. Cabaj: "Right now, the budget for Behavioral Health is not great. As you recall, the Health Commission decided not to advance any cuts or any of the recommendations that had been created by Dr. Katz in consultation with the whole department. It therefore allowed the Mayor to pick and choose what he wished on the list. At least in terms of what's going to affect Behavioral Health directly, is a reduction in residential and outpatient substance abuse services by \$1.8 million, which I think is extremely significant. If this cut happens, it could actually lead to the complete elimination of services for certain age groups and genders. Women's services in particular might be eliminated and services for youth. So it could be a very difficult situation if that has to be implemented.

It also did not add back lots of the Board of Supervisors add-backs. In other words, it didn't get continued in the baseline. So we're still sorting out what would not continue to be funded, and what would be. We don't have all of that information because it keeps changing.

One nice thing is there was some funding backfill, which included some of our SAMSHA dollars. This is good because we get money from the Federal Government, which allows us to do things that would not generate billing because it's really meant for money and services that you couldn't use in other ways. We support our central access team with that as well as part of our placement and homeless outreach team. The grant never keeps up with the cost of doing business, but this year the Mayor did allow us to backfill the grants, so we won't have to eliminate any staffing in that area.

There is another issue that is a cut of sorts. It involves creating a community resource by combining the Urgent Care Center with an Acute Diversion Unit (ADU), which is an alternative to the hospitalizations. It was tied to a reduction in the beds at San Francisco General Hospital, so there will be also a discussion about the reduction of inpatient beds. I believe Supervisor Daly has suggested that money come back, as well as some other things that he's added back, but as we know, that's still in the balance.

I was reading the newspaper this morning just to see where things are at and you may know even more. If you look carefully at the budget it actually includes eliminating 28 positions in mental health, and that's not getting much press because it's usually thought of as administrative. But in fact it would be a problem if those positions are deleted or defunded. It's a very complicated way to help support the long term care services, which have gotten to be over \$5 million a year, and we don't have the resources for that. So there's been some tradeoff, and I think the Mayor felt there are too many new positions throughout the City, and therefore recommended deletions.

San Francisco General Hospital is supposed to eliminate 21 positions, Laguna is supposed to eliminate a little less than 2, 1.75, and ours is 28. Now what I've been told is that the positions wouldn't be eliminated, just not funded, which means you couldn't fill them, and that would be the equivalent, in my opinion, if you estimated it, of at least one to two full mental health centers. So it could mean that we would be unable to fill vacant positions as they come in. We don't have the details yet. It might apply both to the clinical services as well as administrative. So that's what I know as of this afternoon"

Dr. Turner: "I'm really wondering about the impact of all this. It seems so tremendous. When I look at Psychiatric Emergency Services (PES), Edgewood, Westside, all these places, I don't know how up to date my information is. This is from 6/4/07."

Dr. Cabaj: "The Beilinson Hearing budget list is the official services cut proposal. Because the cuts to substance abuse outpatient services are listed generically, no particular program is highlighted, so therefore every program that gets funding is notified. So not all of those would be eliminated but any or all of them could have reductions in their service delivery package that we fund.

Dr. Turner: "So what's the impact on the City and the people?"

Dr. Cabaj: "Well there are two things. Again, as the representative under Dr. Katz and the Mayor, I have to say this is the budget but in terms of an analysis, I think obviously a reduction in outpatient substance abuse services and residential services would truly have an impact.

We've been one of the few counties that really strongly supported substance abuse services, and we know that they really depend on the general fund. So it's a very easy target every year. That's why every year, substance abuse gets listed as potential cuts and every year the Mental Health Board has been very helpful in looking at the funds to support that. There's also another big problem with the Ryan White money, and it's not directly under Community Behavioral Health Services, but it's all now part of our Community Programs; and that's about a \$5.3 million deficit, I believe, which we're also trying to sustain. The Board of Supervisors is also saying that they would try to help fill in. So when you start looking at all of these major issues, as well as their impact, somebody might think \$1.8 million is nothing compared to the \$5.3 million that has to be rescued and so on.

So it's a question of priorities, obviously. But if we had to implement the cuts, I don't believe it would make sense to reduce all programs by that percentage because that could mean some programs wouldn't have enough operational power with the amount of reduction. So it most likely means we'd have to comb through particular programs and look at reductions. And we've eliminated so many programs over the years that we're actually at that point where most likely a big chunk of adult services, a big chunk of women's services, a big chunk of youth services might have to be eliminated, and that's just on the substance abuse side.

There have been lots of thoughts and comments on the inpatient service. The PES is very frequently backed up. Often the emergency room has been going on red alert because they don't have places to admit people when they come into the emergency room. If there are fewer beds at San Francisco General for psychiatry, I can only imagine that would have an impact."

Dr. Turner: "I just wonder if, you know, with the reduction in PES as well as substance abuse services and some of the programs for youth, if that means we see an increase in homelessness."

Dr. Cabaj: "Well that would, and especially if some of the residential services that we're looking at would be cut. That would definitely have an impact. And as I said, it's nice that they've restored money for the homeless outreach team, but unfortunately that might mean there's more homeless to outreach to with some of the proposed cuts."

Mr. Purvis: "Dr. Cabaj, within NAMI there's some real concern about the elimination of inpatient services, even a small cutback. There seems to be an attitude in some places that it's okay. Inpatient services are not desirable. But we know, we have family members that are in acute states that inpatient is almost the only way to go. So that's a particular concern for NAMI."

Dr. Cabaj: "And again, I can explain the only rationale that they had for listing some of the reduction in inpatient services was it was to counterbalance the creation of a community alternative. And everyone certainly wants community alternatives. It would be great if people didn't have to be hospitalized if there was a good option. That's why the creation of 14 new ADU beds as well as an urgent care center, which the belief is that it would help offset some of the PES impact, was linked together."

The Health Commission itself kept that link and that did get passed along, so the Mayor just picked up on what the Health Commission had actually supported. There's also the studies that show that about half of the people currently in the inpatient beds at the San Francisco General are actually not acute, meaning they shouldn't be at that level of care. They should be somewhere else. There are also thoughts that we don't really need that many beds. But one of the problems is they're there because there aren't enough community resources for people to leave the hospital. So it all ties together like that."

Mr. Keys: "Yes, James Keys. I personally would like to welcome the people in the audience this evening. Thank you very much for coming out on this very warm June day. Dr. Cabaj, I don't have a question in as much as I have a comment and I'd like to put this into the record officially. Along with the psychiatric beds, I believe that there are cuts being made for women and children, but you forgot to mention that minorities figured into that prominently.

Each and every year—and again, this is a statement that I'm making—I have for the last three years gone through this budgetary process. I have sat and I get phone calls into Supervisor Daly's office from doctors, men, women and patients from San Francisco General crying out that these budget cuts are going to affect their jobs.

They have to take time off with their work from helping and serving those people who come in needing their help to come and beg for money. This demoralizes not only the workers at San Francisco General but it affects the patients, and people that they're there to serve. I find this to be, in the least, distasteful and I won't say how I feel really about this, yet now we are going to be seeing the Mayor cut more funds. That's going to create homelessness or more homeless people out on the streets, to then create a community court where people who are homeless, people who are sleeping on the streets or who may have to do other things on the street can be arrested and taken to jail. I find this absolutely mind-boggling. If there's anything, Dr. Cabaj, that you can suggest that we can do as a board to fight these cuts, please let us know. Thank you."

Dr. Cabaj: "Well I think certainly what you observe is a process that's happened year after year after year, and as many of you attend the hearings at the Health Commission when they do have comments from the public, that's exactly what happens and people do get very frustrated. And as I said, it's often disproportionate to the substance abuse side because of the dependency on the General Fund, and obviously it has a major impact on minority communities because there's a much greater representation of the minority population in those services. So yes, it has that direct effect when you look at it from that point of view. The budget process is not one I created. I understand, but I think advocacy has been obviously helpful.

I believe the Health Commission had its best intentions in mind when they heard the public comment. It was painful, you know, when people would tell their stories. And their message was we believe we've created the best health system now. There is absolutely no reason to cut or eliminate. So I believe they did in their minds the right thing but unfortunately the process left too many open ends and I think we saw the consequences.

When people call me about what to do on a one-to-one level, I've usually urged them to contact their supervisor and to work with them. So some of the calls you get may have been because of that. But most of our major contractors know that. They know the best thing to do is to call on the supervisors. They certainly have worked – many have said they've gone to the Mayor directly but at this point now it's the give and take. So the Board has to decide on the best action, but I believe any advocacy, any statements of your concerns about the impact that if these things happen of what it would do to the system would, I believe, be heard and certainly would have some power. “

Dr. Shukla: “You mention that part of the motivation in going forward with these cuts were that there were too many positions in mental health. And I was wondering if there was any basis or any inefficiencies that were noted within the mental health system that led him to choose these cuts versus others.”

Dr. Cabaj: “It wasn't so much any one particular department had too many positions. He felt the City had grown too many positions across the board. And I think there was some comment, there were 136 positions that would have been created in the last year, and he wanted it reduced to 104. So it was sort of up to Dr. Katz, I believe, to determine which areas would take that impact. So I'm not exactly sure why mental health was picked. I haven't been able to get a clear picture, other than that we have one of the biggest pools of employees and the primary care clinics weren't targeted because they're getting new funding from Healthy San Francisco, which used to be called HAP – it has a new name now – Healthy San Francisco.

There's additional funding as well as from State monies that are supporting that. So I believe they looked at San Francisco General, a tiny little bit of reduction at Laguna, and then the biggest other employer in the Department of Health is Mental Health. And I say Mental Health in particular because our substance abuse side really doesn't have many employees. All of our substance abuse work is contracted out. But many, about half or two-thirds of our mental health services are done by civil service staff.”

Dr. Moses: “Dr. Cabaj, You know, it's kind of sad to see or to hear you say 28 positions are de-funded. Is there any plan in place as to seek Federal money? Because every time you look around at federal fund, they're making some money available for substance abuse. Can we go for some of that?”

Dr. Cabaj: “ Well we, actually as a county, pretty much try to maximize all of our funds that we can get from the Federal Government. We're pretty good about that. But there's not that much. And if you know the politics, California doesn't rank high often in the current administration for extra money. The Bay Area ranks even lower, and San Francisco ranks even lowest; so whenever there's anything that might depend on Congress, we don't get a lot of money.

We do apply for every grant that we can so we're looking right now at a grant that would expand some services for the impact on children because of methamphetamine use in their families. And we're hoping that we can get that grant. So things like that; but they're all, I

hate to say, nickel and dime. They're small increments but we try to maximize everything that we can. The SAMSHA money is really important. We depend on that a lot, but it also goes through cycles where they may run out or they renew it for only a certain period of time, and then may not continue it. If we eliminate positions we also reduce revenue."

Dr. Moses: "Thank you."

Mr. McGhee: "I just have one thing to say. I think it would behoove all of the board members to meet with your personal supervisors that appointed you. I'm definitely going to meet with Supervisor Peskin, who appointed me, because 1.8 million dollars, as far as I'm concerned, in the mental health area is almost criminal based on where we are in San Francisco with the amount of patients and people we have and homeless as well as the mental health industry. So I would implore that two things happen: (1) that we institute a letter from the Board opposing the cut. I think we should go on record as the Mental Health Board, and (2) I think that each one of us needs to make an appointment with our respective supervisors so we can meet with them on making sure that \$1.8 million does not come out of the budget."

Mr. Keys: "Thank you, Vice-Chair McGhee. I believe that your idea of a letter is a great one, yet to make a stronger statement perhaps we should create a resolution."

Mr. McGhee: "That's fine. But what I'd like to see, Madam Chair, is for the Board to take an official position, however you feel, whether it's a letter or a resolution; but I think it's something that we need to act upon right now. And then I think, Ms. Brooke should help in setting up the meetings with our supervisors as quickly as possible so we can get in to meet with them."

Ms. Brooke: "A letter we could do without having a board vote. A resolution we couldn't do until July."

Dr. Cabaj: "One other area I didn't comment on because it's not directly related to the City budget, but to the State budget. I learned this morning, if you remember the AB2034 money, which we're all advocating for, it was at a joint committee between the Assembly and the Senate, and this morning, they did agree that it should be funded. Now that still doesn't mean it will, because it's still up to the Governor. But they did not agree to support the Mentally Ill Offenders grant, which was the additional new money that came for the mentally ill offenders. So if that happened that would be a grant that we did receive. It would run through this fiscal year, we learned, and about half of the amount of money then would stop. But as of June 30th all the AB2034 money would stop and we would have a deficit of \$2.3 to 4 million. There's no backfill at all discussed about the AB2034 money because it's still so unknown."

Dr. Turner: "Okay, are there any other Board member comments related to this topic? There was also the handout that we received around the growth funds along with Dr. Cabaj's report, the plan for the growth funds?"

Dr. Cabaj: "Okay. I have it as a separate attachment. If you recall, we discussed in here that the State did pass a bit more money along to us for clinical services and support; almost \$2.2 million. That was on top of the \$5.3 million we get. And our plan with that growth fund is what was outlined there.

Basically it's not doing anything different, it's just continuing to fully fund all the adult programs and all the violence response programs. I think, last year I said we were going to only fund one adult program and one violence program, but because of the Request For Proposal (RFP) process, three programs, all whom were within a half point of each other got selected. So we said if the State allowed us to use some one-time money, we would support these programs for that year, but there was no promise funding would continue.

This additional money allows all three programs to continue, as well as the added violence response services. And all it does is help some part-time positions become full-time and strengthen the role of peer employees. It's our plan to basically keep everything that we've been doing going. Otherwise we would have actually faced some potential reductions in the number of clients we could see through the Full Service Partnerships. So this allows us to do that, strengthen our violence response network and enhance peer employment in the system."

Dr. Turner: "Okay, thank you for that Dr. Cabaj. I'm going to open this up to public comment. Is there any public comment relevant to this item? We have three minutes for each person to present and then you'll hear a little ding from the timer."

1.1 Public comment relevant to Item 1.0

Dr. Lu: "Board members and Dr. Cabaj, my name is Dr. Francis Lu, last name L-u, and I just want to say that in July, I will be celebrating 30 years of working in the Department of Psychiatry at San Francisco General Hospital with the inpatient services. And I'm also a professor of clinical psychiatry at UCSF. I have a written document to just discuss the budget issues affecting the Department of Psychiatry at San Francisco General, first of all to inform you of what's happening and secondly, if you so please, to pass a resolution advising the Board of Supervisors to add \$2.368 million dollars in general fund dollars in order to accomplish the following two actions. (The document follows.) And I'm just going to summarize here because of time.

One action we're requesting to be taken, is to prevent staffing cuts in the Department of Psychiatry. This would require \$1 million in General Fund dollars, and there are a number of positions that are going to be cut throughout the Department and we hope that you might support adding back funds to prevent these cuts to outpatient services as well as inpatient services. The second action is to prevent the closure of an ethnic minority focus psychiatric inpatient unit of 22 beds at San Francisco General, and \$1.368 million dollars in General Fund monies will be needed for that. And that's documented on the Beilenson hearing document, the second line item. If you look in the box here it does say that \$1.368 million is the planned reduction at San Francisco General Hospital. And just to be very

clear, this represents one of four units, 25% of the psychiatric beds in the public sector at San Francisco General.

While we support the expansion of community services, we believe it's both too dangerous and unwise to close an entire 22-bed inpatient unit before these community alternatives have had a chance to demonstrate to what extent they can eliminate the need for locked beds, as well as divert the planned 30% of patients that normally would come to PES. That was in the Department of Public Health (DPH) plan that was submitted. For example, according to that DPH plan patients that need medical clearance, seclusion restraint or hospitalization would still come to PES and I ask, you know, how will the police and others determine where to send the patients so as to offload 30% of them. Also, we've had a drastic reduction in hospital beds in the City from 176 to 71 over the past 16 years, not including San Francisco General. Also in April, Sutter Health announced the closure of their 28 beds next year, and so we are very concerned. And finally, concerning the four ethnic minority focus units, which unit do you cut, the Asian focus, the Lesbian Gay Bisexual Transgender (LGBT) focus, the Black focus? And so I ask for your support in this matter. Thank you."

Dr. Lu's Written Submission:

Budget Issues Affecting the Department of Psychiatry at SFGH Document:

TO: San Francisco Mental Health Board

FROM: Leadership of the Department of Psychiatry at San Francisco General Hospital
Robert L. Okin, MD, Chief; Mark Leary, MD, Deputy Chief; Francis Lu, MD

DATE: June 13, 2007

RE: Budget Issues Affecting the Department of Psychiatry at SFGH

We are writing as leadership of the Department of Psychiatry at San Francisco General Hospital (SFGH) to inform the San Francisco Mental Health Board about our deep concern on two separate issues in the Department of Public Health (DPH) budget as they relate to the SFGH Department of Psychiatry. Comprehensive care requires the need for high-quality, community-oriented, culturally competent hospital care for patients when they need 5150 emergency evaluation/treatment in a locked setting that can provide comprehensive medical assessment/treatment. The partnership between our community services and SFGH is critical for the health of our patients. **Therefore, we ask that the San Francisco Mental Health Board pass a resolution advising the Board of Supervisors to add \$2.368 million in general fund dollars in order to accomplish the following two actions:**

1. **Prevent staffing cuts in the SFGH Department of Psychiatry (\$1 million in general fund dollars).** These cuts will affect many programs in the Department. 200 mentally ill outpatients and 125 mentally ill inpatients with complex medical and surgical problems

will otherwise not be served because of cuts to psychiatrist and psychologist positions. Hundreds of inpatients will not receive adequate linkages with their families and community providers as they prepare for discharge, because of the cut in inpatient social work. Certain other crucial administrative cuts are scheduled to occur which will damage the Department's infrastructure and ultimately compromise clinical care to patients. Because of a very severe recruitment and retention crisis of psychiatrists, these cuts were necessary to bring psychiatrist salaries closer to the salaries paid by other organizations such as the community behavioral health services of San Francisco, San Mateo, and Santa Clara counties so as to recruit and retain psychiatrists.

2. **Prevent the closure of an ethnic/minority focus psychiatric inpatient unit (22 beds) at SFGH (\$1.368 million in general fund dollars).** This represents a cut of 25% of the psychiatric beds in the public sector at SFGH. While we support the expansion of community services, we believe that it is both too dangerous and unwise to close an entire locked 22-bed inpatient unit before these community alternatives have had a chance to demonstrate to what extent they can eliminate the need for locked hospital beds as well as divert the planned 30% of the patients that normally would come to PES. For example, according to the DPH plan, patients that need medical clearance, seclusion and restraint, and/or hospitalization among other conditions would still come to PES; how will police and others determine where to send patients in emergency 5150 situations? It is presently very difficult to get a patient admitted to a hospital bed because of many reasons including the decline in the number of psychiatric beds in the city from 176 to 71 in the last 16 years (exclusive of SFGH). Furthermore, Sutter Health announced in April closure of another 28 locked inpatient beds at CPMC next year; CPMC is appealing. The loss of 22 locked inpatient beds at SFGH will make it extremely difficult for our mental health system to provide this level of intensive emergency care. Finally, the four SFGH community inpatient psychiatric units also constitute nationally and locally recognized Ethnic/Minority Focus Programs providing culturally competent care for Asian, Black, Latino, women, LGBT, and HIV/AIDS patients. Cutting one of these units will jeopardize the integrity of the Focus Programs to care for these underserved populations who experience profound mental health care disparities. Ethnic/ minority populations will be disproportionately adversely affected since these services do not exist at any other San Francisco hospital.

Mr. Keys: "Excuse me. Dr. Lu, can you stay, please? I have a few questions. Dr. Lu, James Keys. We've spoken several times on the phone before. Welcome and thank you for coming out."

Dr. Lu: "Thank you."

Mr. Keys: "Dr. Lu, how long have you been in San Francisco General again?"

Dr. Lu: "30 years this July, July 25th."

Mr. Keys: "Thank you. With these cuts what is going to happen to those people who are not receiving services, in your expert opinion?"

Dr. Lu: "Well I'm very concerned that right now we're having a backup, as Dr. Cabaj mentioned. We're at red alert status. We have no beds upstairs and the emergency services are so full they can't even take people coming in on the 5150s. And they're bringing these psychiatric patients on 5150s to medical emergency rooms at Moffitt and California Pacific Medical Center, and St. Francis Hospital. These are facilities that physically do not have a psychiatric emergency capability, nor the staff. These patients are waiting days to be in these facilities right now. So we're very concerned that with the loss of an entire unit, that this situation is going to melt down.

I just wanted to comment, again to inform you and also, if possible, ask for your support to try to reverse the situation, which I think would be to restore the funding for the inpatient unit and continue the funding for the community alternative. I don't see this as an either/or situation. I think this is a place where we can come together.

I also am making all these statements in the context of the dreadful, dreadful cuts that we just heard about; so I don't mean to, say that we're the only ones in need. But I just want to make this very clear that we're talking about 5150 emergency patients that are sometimes in need of a locked setting with expert medical assessments. And when the police pick up someone on the street, are they going to take the person to PES, where you have a medical emergency service next door and medical consultation that are able to do chemistry tests and a CAT scan, and drug screens, or are the police supposed to bring the person to the urgent care center, which may not have all of those services? I don't have the details, but I think that, again, it's not an either/or. I think we can try to work on both."

Mr. Keys: "Excuse me, Dr. Lu. Dr. Cabaj, do you know if there is a backup plan for what's going to happen to people who are coming in for help or services from San Francisco General from the Mayor's Office if these cuts happen?"

Dr. Cabaj: "Well the alternative is supposed to be this community center. My understanding is they wouldn't close the beds until the center is up and running. I believe it's linked that way. And unless the language changed, it also had a reduction in PES staffing too, which also needs to be highlighted, I believe. I don't know if that changed. The proposal changed a lot, but the belief is the new urgent care center with the ADU beds would be the alternative; so people would be brought there.

Now the question has come up how would we train the police, who would work with them? You may be brought in because of the training program that you support, and about how we address who goes where. And it's a question of who does that screening. And I think the medical issues that Dr. Lu brings up are very important ones to consider."

Dr. Lu: "Thank you, Dr. Cabaj. I just want to make it very clear in my reading of the DPH plan, it kind of implies that those community alternatives are going to be open first and then the reduction in the beds. But if you read the document carefully, it clearly states that

January 2008, the unit is going to close, and then these alternatives are going to come up, and there's no overlap period at all. There's no room for error, when we're already on condition red 30% of the time in March and April. So I think this is a very serious matter and I think this could really blow up in the Mayor's face, to be very honest, and I must say in the year 2000, when DPH proposed the closure of an inpatient unit at that time, our current Mayor, Gavin Newsom, was very much in favor of supporting the unit. He visited General Hospital. He was one of the first supervisors to support us. So I hope that some consideration will be given to this, and I certainly wanted to inform you of this."

Mr. Purvis: "I'd just like to add a comment. This is the very issue that I was commenting on before. We know that family members who are part of NAMI have adult children who are in jail or on the streets for lack of appropriate inpatient care in a timely manner. So I'm sure, I know that we'll be able to support the points that you're raising."

Dr. Lu: "Thank you very much."

Ms. Kellum King: "My name is LaVaughn Kellum King and I'd like to ask you has anyone asked the Mayor to come over and take a tour of the facilities and show him what the devastation is and how it can worsen."

Dr. Lu: "That's a very good idea. I think we could certainly make every effort to do so, yes. Thank you very much for that idea. Certainly any support that the Board could give would be much appreciated. Again, thank you very much for the time and consideration."

Dr. Turner: "Thank you. I want to open this up to further comments from the public."

Member of the Public: "Hi. My name's John Cleveland, Sr. And I don't know what the amount of the funding for the Behavioral Health Court system was exactly, but I think that if they can have a place out of jail to go to, maybe some construction job. Some of these buildings need remodeling or some of these old buildings need to be taken down. If the City can hook them up with something like that to where they would have a better life, I think that it would be working more."

The way that it's not funded now is because they end up back into the system again. You know, they go out so far but it just opens up another door. They have nowhere to lead them anywhere, to construction or to something to that affect that gives them a better life. So if the funding was there or if the City could come up with some wrecking crew or something and put it together at the cost of equipment and then some good construction leaders, maybe they can branch out with people being more productive instead of spending so much time nonproductive in jail. And that's about all I have to say about the Behavioral Health Court system or maybe a system that can take off with that and be more helpful to the City and maybe the County. Thank you."

Mr. Keys: "Mr. Cleveland, I just wanted to comment that you have two actually excellent ideas about San Francisco creating a sort of infrastructure of work for people who have little skills or who can be taught some skills to do some basic work that we need done."

Construction is one of those things, cleaning the City is another one of those ideas. That's actually a fantastic idea, and to give a person work is to give a person hope, and give a person an outlook of a good future for themselves. So I wanted to thank you very much for your comments."

Member of the Public: "Hi, my name is Sheri Erlinson. I'm from the Citywide Case Management Forensic and Forensic Linkage Project. When I came to San Francisco, I was homeless and everything else, you know. And I've been in 16 different programs here. I know what they're all about. The ADUs I've been to are very nice programs. I've been in San Francisco General Hospital 38 times, and they've helped me each time I was there.

Why would they cut this budget down? Because, you know, I've even been in jail because they didn't know where to put me. My friends at Citywide Forensic are asking, what are we going to do when they're going to close General. What are we going to do, you know? And I don't know what to tell them. You know, I'm just a client like they are. They're just so worried about what happens. What are we going to do next, you know?

There's going to be a lot of homelessness and then there's like the pregnancy. I almost had my son in a program. They take care of programs very well and I don't think they should be closing down General or any of the hospitals, you know. I already know that Davies closed their program now, which I didn't think was right, because I had an ex who used to go to that hospital, and they helped her out very much. I've had lots of friends of mine go to these different hospitals. They needed it. And I know they're overcrowding hospitals and also boarding, ADUs because they've got so many people in jail now waiting to get into an ADU. Two to three months waiting. They're in jail waiting for an ADU for two to three months, and it really just hurts me to see them. Every week someone goes to the judge, and the judge says 'you can't go to an ADU because they're still trying to get the people out of General'. That's how bad the system is now. What's going to happen when General completely shuts down to these ADUs? It's going to be overcrowded and more people are going to go to jail. There's going to be more people who are homeless. They're going to be all in the Tenderloin, you know. I've been in the Tenderloin. It's no good. That's all I have to say."

Member of the Public: "Good evening. My name is C. W. Johnson. I identify myself as emotionally disabled, which just means I'm manic-depressive and I suffer from schizophrenia. I'm also an advocate in association with the Mental Health Association.

One of the things that I feel, well three of the things that I feel is that we have a lot of homeless because we don't really have good homeless prevention. I think if we're going to have money, money should be toward that, toward helping the homeless, most definitely. I've been almost evicted a couple times myself for what I consider a disease. Also, I think that this seems not to be talked about or even looked at, is a transitional support for people who are mentally ill. When you have lived on the streets a certain way for two, three, maybe four years, you develop habits and a way of living. And I think that any training around training people how to get their lives back would be a great way to prevent people from becoming homeless.

Third, but not last, I think housing is really a problem. I think – I forgot the name of the program, but they do a really good job of putting emotionally disabled people together. They have these really wonderful houses. Progress Foundation, that's it. And I think that as we move people, there's no upward movement. It's just like you get in this hotel and it's beautiful and everything but that's it, as far as you go, you know. And I don't think life is actually a monopoly. I think you should be able to go as far as your emotional stability should be able to take you, and I think we really need support around those things and I would definitely like to be a part of anything like that if you guys come up with it. So thank you very much for your time."

Member of the Public: "I'm Kathleen Connolly. I'm the Director of the Citywide Case Management Forensic Program. We're a program of UCSF. And I just wanted to piggyback on Dr. Lu's comments about the hospital inpatient beds.

I think it would be a travesty to lose those beds. Our community is already at its limit as far as the ability to get our folks into the hospital for stabilization when they really need it. Our program works with some of the most severely mentally ill folks in the City. I've been with the program for ten years and I actually used to work out of psych emergency (PES) and my impression is that probably both options are needed. We need to keep the inpatient unit open and then add this other community type program to relieve some of the pressure from psych emergency. But I don't think it can be an either/or because I think, that they're two very different functions.

I think an emergency room has to be trained and run as an emergency room, and the folks that are going there are not people that do not need to be there. The reason they're overflowing is because every single person needs to be there. We don't even take people to the hospital when we know that there's a slight chance that they wouldn't get hospitalized. So they have to really meet a high standard, as it is, and the people that are in the hospital that are on administrative days, they need to be there because there's no place to send them once they are stable. And we're lucky if we can even get them in long enough to stabilize them. So I just wanted to really advocate for that, and stress the importance of it as a community case manager working with all these folks. Thanks."

Mr. Keys: "Ms. Connolly, could you just briefly explain what your organization does?"

Ms. Connolly: "We're an intensive case management program. We're actually, part one of the FSPs that was funded through the Mental Health Services Act (MHSA) money. We've been around for about 20 years, serving mostly high users of both the inpatient psychiatric units and psych emergencies. So we provide intensive case management and wrap around services to folks for as long as they need it."

Mr. Keys: "How are people referred to your organization?"

Ms. Connolly: "Mostly through the inpatient unit from various community providers. If someone's in an outpatient clinic and they need a higher level of care, we'll get referrals

that way. My program is the Forensic Program so we get most of our referrals through jail aftercare, so we're working with folks coming out of jail."

Mr. Keys: "What would happen if funding were to be reduced or stopped?"

Ms. Connolly: "I think that the City would lose a huge service. We probably have about 500 clients that we serve at our clinic, between three different case management programs."

Mr. Keys: "So the funding that's going to be stopped for San Francisco General, how is it going to affect your organization?"

Ms. Connolly: "Well it does trickle down. We're part of the Department of Psychiatry for UCSF, so when there are cuts that need to be taken, they are spread out amongst, not just the inpatient unit, but they trickle down to the various outpatient programs. There's Citywide Case Management, there's Crisis Resolution Team, the ED Case Management Program, and various other smaller programs I think. So yes, we're in the process of actually having to cut a few positions right now."

Dr. Turner: "Ms. Connolly, if you have the time, and actually for anybody who represents programs, if you want to just email us a few lines that you think will help us, we will put them into our letter." I think sometimes the more facts we can have, it's helpful to us."

Ms. Connolly: "I'd be happy to do that."

Member of the Public: "My name is David Keck. I want to shed some light on why I feel I am lucky. The reason I'm lucky is because I have services, I am receiving services. I have housing that's owned by the City, and I can afford it. I have services provided through St. Mary's Clinic, part of St. Mary's Hospital. It has a Catholic training school. And all my coverage is included. I mean, I get about a thousand dollars a month in treatment. It's offset somewhat by Medicare and Medi-Cal.

But I want to also shed some light that I am hearing impaired. I go to the Center of Deafness, UC Center of Deafness at Laurel Campus and there I see a case manager weekly. I see a case manager and a social worker for an hour each. And as I need it, I see a psychiatrist because I had an automobile accident long ago and I had head trauma. So that's what's keeping me afloat and I want to offer my services as a volunteer. I want to be utilized in any possible way that I can to structure programs, to be of help for the people that are trying to come up.

I am a peer counselor now but I'm not working, for one reason or another. I'm not sure why, but I used to be the assistant to the coordinator for a program, and we were servicing 25 interns scattered in ten different centers, hospitals, clinics and that sort of thing. And I just put it out now that I'm a volunteer, and I want to be utilized in any way that I possibly can to support what everybody's trying to do. Thank you."

Dr. Turner: "Thank you. We need to get this letter out as soon as possible; so anybody who is going to write anything to us, speed is of the essence. I think we'll probably get it out Friday morning."

Member of the Public: "My name is Alexandra Kutik. I was dismayed and concerned to hear about proposed reduction of inpatient beds at S.F. General Hospital based upon the expectation that community-based services would fill in the gap. Have we not learned from the mistakes of public policy dating back to the 1950s and 1960s when de-institutionalization with a similar expectation resulted in the streets along with jails and prison populations serving in place of those non-existent community resources? Promises made then remain broken. It is unconscionable that we would ignore this history lesson and make this same promise again, particularly when we already know that resources are not available."

I am wondering what the connection is between the proposed elimination/de-funding of 28 positions in Mental Health and the allocation of MHSA FY'08 growth funds for additional/annualized/part-time to fulltime CBHS staffing for MHSA implementation. If, in fact, MHSA funds are being used to supplant City costs, this is in direct conflict with the spirit and intention of MHSA. Once again, thank you for the opportunity to present these comments."

Dr. Turner: "Thank you. Is there any further public comment? Okay, thanks for all of you who presented to us, and seeing no further public comment, public comment for this item is closed."

Item 2.0 PUBLIC HEARING ON THE ANNUAL UPDATE TO THE MENTAL HEALTH SERVICES ACT PLAN (MHSA)

We'll move at this point to the hearing on the annual update for the Mental Health Services Act. We all received this in our packets and hopefully members of the audience have it, but if not, there are copies in the back that Ms. Brooke has supplied.

2.1 Presentation

I'll start off with a few things I noticed in the report. First of all, I just wanted to say I'd like us to add that hearings were held at each of these meetings and these hearings tended to be quite long in terms of getting public comment. They moved up to two hours, and Mental Health Board members who were on the taskforce facilitated those hearings; so I think that would be important for us to add in terms of our process.

This is a comment, and then I have a question. Maybe you can help me with this—in Part A, I guess on page 7, we talked about implementation challenges. And before I noticed the heading, and I was reading I was saying oh, no, we've said all these things we've done wrong. And then I realized that's what we're supposed to put in the report—the challenges. But I would think it would be important to, at least for our own selves

internally, if not in this report, to explain how we're going to avoid having these kinds of problems, you in the future.

There were things like the plan was approved, but positions couldn't be posted. Some of these things we can't do anything about; but as of December 2006, none of the clinical positions were hired. That's on page 7 in the middle, and I was wondering about the employee turnover, and the fact that we were short-handed to handle contract renewals. We might do a better job of just explaining how we are managing these things, not only for the presentation to the State, but also for our own internal work on ourselves.

The staggered funding of MHSA was a challenge for our financial accounting unit. I guess now we're doing better with that. Sometimes this is the jargon that is used, but when we talk about full service partnerships, we're talking about various organizations that are our partners; but yet we also use the word "partners" for clients. So I'm wondering, are we talking about people or organizations? Maybe you can just explain the terminology a little bit."

Dr. Cabaj: "Well thank you. Those are excellent comments. Actually, if you notice, the timeframe is the problem. This is a report that's supposed to be through December 2006; so most of those challenges were met and resolved by now, but we don't quite comment on that. Next year it would say that. So we were a little uncertain about how to do that, but I think if we can incorporate some of these remarks, that would help.

The State was very adamant about creating that term 'full service partnership.' We had already been using terms like single-point of responsibility. The program we just heard about, Citywide, is that. The ACT program uses another name, 'assertive community treatments,' and we felt that there were plenty of terms that were already out there, but the State wanted to come up with a new term; so they came up with 'full service partnership.'

Usually partnering does mean contract agencies or sister organizations like the police or the courts. So, I'll have to reread this but I thought they would weave together. When they use partnership, it usually meant to the clients because of their needs, and full service partnership implied everybody working together to help that client, doing whatever is needed. It didn't imply who was doing it, necessarily. The partners are who do the work, so we'll see if we can make that clear.

The reason we even have the term CSS, Clinical Services and Supports, is because the State did not want to use the term "system of care", which we've been using for many years. They thought to transform the system, you had to come up with a new term so that's what they did."

Dr. Turner: "It was a little hard to read without tables. Maybe you aren't supposed to put tables in. I know the State has all these formulae about how you have to present these things. But it would have been a lot easier to read it if I had those tables. Here's the number of proposals on page 3 that we got, and then it starts explaining on page 4 who got them

and for what, and does that account for all of them? It is unclear. A table, I think would be really helpful for people to understand."

Dr. Cabaj: "I'll see if we can do it. Again, Maria O'Malley was one of the major coordinators of the Update. I actually encourage all of my staff to read it, because I thought it was a well-written report even if there were some questions on content here and there. But it's one of the rare times where it was actually enjoyable to read, I thought."

Dr. Turner: "It is actually well written."

Dr. Shukla: "I had a question about outcomes and again, your point's well taken about how this is actually dated December 2006, and that may be a little bit early; but I think there was a public comment that was very well taken about programs being cut at the same time that services are expanded. And I think that the only way to really justify doing that is if you are supplanting existing programs with better programs or fuller programs, or programs that can actually show that they produce better outcomes. And I think a really important piece of this in the next phase will be to actually demonstrate that all of these new services are actually improving the state of health of these patients. Especially with all the cuts, I think that's vital."

Dr. Cabaj: "Excellent."

Dr. Turner: "I think the sad thing is that even if this is helpful, you've got all this other data related to the cuts, which may show harm, and then it's kind of hard to know what's helping and, it gets over-shadowed."

Dr. Cabaj: "I've been paying attention to that question of supplantation and there's so many interpretations of it. I tried to use this term to address the 28 position deletions. But there are two interpretations: that it only applies to State funding, the State General Fund, and although I've heard it interpreted for the County it would be pertaining to the '04/'05 level, and I've been told that we still would not be below the '04/'05 level because of cost of living and other increases to the whole system and other growths. So it's a technicality, but I think it's tough. The outcomes are a key part of this, and it's too soon to assess the outcomes, because they've just started. So the outcomes will be one of the key parts, and we will be following them not only for the clinical services but as the new monies come along for prevention, early intervention training and so on. That's going to be a key issue."

Dr. Shukla: "Is there a general sense of how well these programs are doing?"

Dr. Cabaj: "We feel confident because we've had the working model of a program like Citywide and our AB2034 programs. So basically the Full Service Partnerships are just like that model, except we are able to fund more services for clients. And those models have been very successful, as you know, reducing hospitalization, reducing time in jail, increasing work activity, and increasing housing. We have no reason to doubt that those same things will happen with the FSPs. But again, it all depends on the funding. So it's too

soon really to know the impact of these programs. But I can't believe it would be any different."

Dr. Turner: "Any other Board members want to make comments or ask questions about the Update? Another point is that Board members here are doing program reviews for each one of the programs that was funded. We selected them specifically for that reason."

Mr. McGhee: "I just have a question. You know, in reference to the reduction, Dr. Cabaj, I think with the 160 programs we fund or something like that, how is that \$1.8 million going to affect some of those organizations that are doing a pretty good job?"

Dr. Cabaj: "The \$1.8 million you're talking about? As I mentioned, Dr. Katz and the Mayor did not specify any particular programs. That's why every one is listed. So if that cut went through, which we really hope your advocacy and other input might prevent, but if it came through, we'd have to determine whether we do a formula of a certain percentage to all programs. But I worry again about the ability of a program to function if you go below a certain level, or target a particular program. But, in the past we've always honored programs for children, minorities, and for women. And if we try to keep with those same priorities, we actually would still bump up against having to cut some services into those areas. So I am worried about how we would roll that out."

Dr. Turner: "Any other Board Members want to comment? Let me open this for public comment related to our presentation on the updated report. Are there any members of the public who would like to make a comment? There is a three-minute time limit."

2.3 Public comment relevant to Item 2.0

Member of the Public: "Hi, my name is Sheri Erlinson. When I first came to San Francisco nine years ago, I didn't have food or housing. I made poor decisions because I didn't have the right psychiatrist or the right meds. I've been hospitalized. I got referred to Citywide by SOMA because I've been hospitalized too many times in another state. I have not been hospitalized since January – February 2005 because I've become stable on my meds.

I pled to a crime that I did not commit in 2004 so I could get out of jail. I got in trouble for violating my probation many times from 2004 to 2006. In May, I got arrested and sent to jail for two months, then I got into Behavioral Health Court (BHC) where I met Monica, my caseworker. I like Behavioral Health Court because they allow me to work on recovery and not as punishment. I can think about myself as a success and not just another criminal.

My goals right now are to become my own payee, to deal with my fears, to have my own housing, and to own a horse therapy ranch for people with mental illnesses. Citywide helps prepare me to do these things. I have been sober for one year, and I have accomplished more goals in my treatment plan this year than the year before. Thank you."

Ms. Kutik: "Throughout most of the report, MHSA-funded FSPs and other agencies are not identified by name. This seems like a curious omission, particularly for readers who are members of the public.

II. Efforts to Address Disparities

B. Outreach (page 17)

I participated in the "consumer and community orientation of the RFP review process." I served on one of the review panels and was the only consumer/community member, despite the fact that two others had signed up and were scheduled to participate. Given my experience, I wonder whether there is a discrepancy between "one-third of various panels were composed of consumers and/or community members" and the actual number who participated in the review process.

I. Program Services – Implementation

B. Key Transformational Activities (page 8)

C. Implementation of Full Service Partnerships (page 9)

One of the "five fundamental elements" of MHSA to which SF remains committed is "wellness/recovery/resiliency focus." While these sections acknowledge the sea change required of both CBHS and contracted providers – from a medical model treatment philosophy (client impairment) to a recovery model (client goals and functions) – the conclusion is that "additional training on the recovery model ... is a priority." I would suggest that this is not simply a priority, but an essential and necessary element of SF's plan that should have been part of implementation prior to the implementation of FSPs.

III. Stakeholder Involvement (pages 19-21)

IV. Public Review and Hearing (page 21)

The recruitment and participation of consumers and families in the MHSA planning were successful and exemplary. Given the lack of written public responses to the report during the 30-day period ended 5/30/2007 and the lack of attendees at this public hearing, it seems that current outreach efforts for the implementation phase are inadequate and in need of expanded action.

I attended a recent community forum of the MHSA Advisory Committee. I requested that CBHS put me on the distribution list for both future Committee meetings/community forums and job opening flyers for employment of consumers and family members. To date I have received no information as a result of either request."

Dr. Turner: Thank you. Will you please send us your comments in writing? We will include them in our letter."

Ms. Kutik: "I can provide them before the deadline."

Dr. Turner: "Thank you. Is there any other public comment on the update?"

Member of the Public: "My name is Laura Barber. On page 6 on violence and trauma recovery, as the lady stated earlier, they didn't mention the name of the agencies who received the money for violence and trauma. I would like to know, can anyone supply me with the agencies that received the money? They said one agency in the Mission District received money, and then one in the Western Addition, and one in the Bay View neighborhood; but there is no name who received the funds, no agency name. Can that be given out?"

Dr. Turner: "The Instituto Familiar de la Raza, and Urban Services, YMCA. Those two were for violence and trauma recovery agencies, receiving \$120,000 each."

Dr. Turner: "We often don't answer questions but the information was sitting right here on the table. Okay, any other further public comment? Seeing none, public comment is closed."

2.2 Board discussion of Possible Board responses to the presentation

Dr. Turner: "I inadvertently went to public comment before we talked about Item 2.2 so we'll go to that now, before moving forward, and that is Board discussion of possible responses to this topic."

Let me ask a question instead of a response. This report will get some revisions before it will be submitted to the State with comments and that will all go together; When does that get submitted?"

Dr. Cabaj: "I believe it has to be to the State by June 30th"

Mr. McGhee: "So actually this can be revised. This is not the final report."

Dr. Cabaj: "I have to revisit the technical side. This is one of those weird ones where there is supposed to be public comment that could or could not be incorporated. It might be just the addendums. And then the public hearing, which is this, which we also would usually attach as comments. But I will clarify this, because if we can go back and revise it with some of the things that were suggested earlier, I would definitely want to do that. If not, we may incorporate them as comments to the report. But one way or the other we'll make sure these things are noted."

Dr. Turner: "It seems to me that a really high percentage of the proposals that came in got funded. That is interesting in relation to Ms. Kutik's comment about the difference between the public hearings where there were so many people who came out and we heard about so much need everywhere in the City; and now there's not so much response."

I guess what happened is that these areas of focus got selected and so the RFPs just focused on them. So the people who are in those areas where we prioritized are probably happy, but other folks in other areas of the City, who were are not happy but they're not here, and that's your point."

Dr. Cabaj: "Yes. And also I think, as you've seen in other processes, there's always a lot of excitement about how to spend money and how to prioritize the funds. Watching it unfold is sometimes not as interesting; or people watch it from a distance. But usually when you have a voice on how you actually will shape a program and design how money goes, you'll get many more people interested. So if we get significant new funding, I'm sure we'll have more public response as we try to add or expand programs. But I appreciate those who are here tonight. I think the Mental Health Association was helpful too in getting the word out on tonight's hearing."

Dr. Turner: "Well the difference too is that we're having the meeting here, and that's not convenient for everybody. We went around to every neighborhood in the City during the RFP process."

Dr. Cabaj: "Yes. The Community Advisory Board is rotating throughout the City, so we can make sure that at least people can come more conveniently if it's possible."

Dr. Turner: "So then public comment is being obtained from all of these community meetings."

Dr. Cabaj: "Yes."

Dr. Turner: "And it is being compiled?"

Dr. Cabaj: "Documented, right."

Dr. Turner: "Good."

Dr. Shukla: "That doesn't have to do with this report though."

Dr. Cabaj: "No, it doesn't have to do with this report. It's not even a State requirement to hold these community meetings, but we wanted to because I would not want a system unfolding without public review and support, and especially as we are moving towards that recovery model and community-based services, the community's got to be involved."

Mr. McGhee: "Dr. Cabaj, would you be able to get us, the Board, a final draft before we have to submit it on June 30th?"

Dr. Cabaj: "Yes, I will find out tomorrow what the technicality is and you will get copies of everything before it's sent."

Dr. Shukla: "Before the State makes a decision regarding the second round of funding, what additional information are we required to provide, or do we plan to submit to them in addition to this document?"

Dr. Cabaj: "Well the current plan is for three years; so there's no more funding in store, unless we had a radical, huge influx of money, which isn't going to happen, in which we could maybe fund some of the programs we couldn't fund previously. If you recall, some

of you who were on that taskforce, and we funded about four categories in each of the groups that were listed, but there were clearly other things that were listed that we couldn't fund. So one thought is if we had extra money, we could just go revisit the plan and look at funding additional new services that were already approved in the plan, but not fundable; or we could expand current services. But any new dollars, like for prevention and so on, we're waiting for the State to tell us what the role of public comment is or not. That's why we did convene already the subgroup or taskforce on the education and training.

They're considering now a four-year plan. They decided to incorporate one year into the process because it took them a long time to respond and so on. Then most of the money will go back to the County to determine how to use it, and at that point we'll probably have to have a whole new process. I don't know if that clarifies the process.

What theoretically is supposed to happen, and again, the State keeps changing the rules even as we talk, but after '09, '09/10, I believe, all the money will be put into one lump sum for the County, meaning the money that was teased out for education, for prevention, for clinical services; then it's up to the County to come up with an integrated plan, not having these separate plans.

What's been frustrating for most counties is why do we have to have five separate plans? Why do we need an education plan? It really all fits together. A public comment was made and others said we can't do many of these things without training. It'd be great if we can incorporate the prevention, early intervention now. We all really were demanding that the State please give us the money now because we'd like to incorporate it into the original plan. But in the State's wisdom or decision-making process, they are keeping it out separate. Then within two or three years, it will all be put back together, and then it will be up to the counties to do sort it out. At that time, we'll definitely want another public process."

Dr. Sukla: "I think my question was just trying to address at this point, if the funding amount will not be changing then. The question may not be how the money will change in terms of who receives the money, but rather how well again that money is being used and how the programs are up and running, at least at this time."

Dr. Cabaj: "Right. That's why we'll be following the outcome information and start appropriating that into our reviews, as well as reports that you would get; and I think it'll be a major factor in deciding on future uses of additional dollars."

Dr. Turner: "Okay, any other Board responses?"

Mr. Purvis: "I just have one question. I don't know if this even fits right here but is there anything new on the possibility of getting additional Proposition 63 funds? We've been talking for a year or more about possibly getting funds that other counties have not fully allocated."

Dr. Cabaj: "If you'll recall, I mentioned, we sent a letter under Dr. Katz's name and the Mayor's support to ask for \$26 million more for additional full service partnerships and we've not heard anything back from the State. That was about three months ago. Except we heard a little comment that implied that they did get the letter. That's all I know."

Dr. Turner: "If there's no further Board comment I will move to our reports."

Dr. Cabaj: "I want to thank you for your great comments and support. I'm glad we had comments from the public. We will move forward, and I'm glad when I can be here as long as I was tonight. I've got to get ready to get back to Sacramento so thank you very much."

Dr. Turner: "Ms. Helynn Brooke will now give her brief report."

Item 4.0 REPORTS

4.1 Report from the Executive Director of the Mental Health Board

Ms. Brooke: "I'm Helynn Brooke, Executive Director of the Mental Health Board, and I first want to report that our program reviews are up and running. James McGhee completed a review of Community Vocational Enterprises, and James Keys completed a review of Larkin Youth Services; and we have reviews set up for the Family Mosaic Project and Instituto Familiar de la Raza, and one with the Mental Health Association. We are in the process of setting up ones with Walden House and the Family Service Agency, along with one for Citywide. We will continue to move through the rest of the MHSA programs so that the Board can get a real intimate idea of what's happening. One of the reasons the Board does these reviews is to really understand what clients need and what they're receiving so we can be much stronger advocates."

The second thing I want to call your attention to is a play called "The Spot." The next showings are Thursday and Friday at the St. Boniface Church in the Tenderloin. It's on Golden Gate. There's a flyer in the back.

It is a play about recovery, and about being in the jail system unfairly, and I highly recommend it. Geoffrey Grier is the director, and he is in recovery himself. You are asked to pay by donation, and they even have snacks; so I encourage you to go. Curtin goes up at 8 o'clock Thursday and Friday.

Finally, the Board collaborates with the Police Department for the Police Crisis Intervention Training that we developed. We will have our 22nd training next week. Over 600 officers have been trained, and at every training, we hear about yellow alerts and red alerts at San Francisco General and where am I supposed to take people."

4.2 Report of the Chair of the Board and the Executive Committee:

Dr. Turner: "Thank you. Just a few things. A reminder that June 19th, Tuesday, is the hearing on the proposed reduction in health services; so that's a time to make more comments. The meeting starts at 3:30 p.m."

We just recently, on May 31st, had an awards reception and it was wonderful; and I've thanked all of our Board members who participated so much and provided so much leadership in this event. We had about a hundred people there. And one of the things that came from it, I just wanted to read because I thought it was a very, very important letter.

A letter came to both James McGhee, Vice-Chair, and me from Judge David Ballati, and he's the judge that we wrote to make sure that Behavioral Health Court stayed intact and funded and ongoing in its same spot; and that happened. And so he wrote to us: 'On behalf of the Superior Court of California, County of San Francisco, I wish to thank the Mental Health Board for selecting our court's Behavioral Health Court as a recipient of the Criminal Justice Response to Mental Illness Award. I attended the awards ceremony and was honored to see that the Behavioral Health Court was one of many distinguished and deserving individual agencies and programs selected for special recognition. I can assure you' – this is why I'm saying this on the record – 'I can assure you that the San Francisco Superior Court will continue to work with the criminal justice partners in crafting innovative practices and programs for people with mental health issues who become involved in the criminal justice system.' Anyway, a few other things, and he signs David Ballati, Presiding Judge. And that's a very, very important statement, and it's the kind of advocacy on the part of the public and this Board I think that can make things like that stay alive. And they don't if we don't really fight for them. So that was really good. One of the nice outcomes, was getting something like that in writing.

The other thing that we've done recently is to do a showing of the film, "The Bridge" moderated by Board Member Kevin Hines. Kevin's not here tonight. He facilitated a discussion about the film "The Bridge" because he is an advocate for a barrier on the Golden Gate Bridge. He was part of the film. And there was a fantastic showing—all in all, a few hundred people. And I think a lot of us faced seeing the film, those of us who hadn't seen it, with some trepidation because it's not exactly an upper. However, the film was so well done, I think we ended up agreeing with Kevin that it was actually a very important film with an important message, and I hope we do more things like that with other Mental Health Boards. This screening was done in conjunction with the Marin Mental Health Board."

4.3 Planning Committee Task Force Report:

Mr. Purvis: "I just wanted to say at this point that I was very sorry that I had to miss the actual awards ceremony. If people saw me coming in tonight, you see how difficult it is, and I knew that would be an event where meet and greet would be important. Tonight I can just come here and sit. But all the feedback I've had is that it was a very wonderful, successful event."

Dr. Turner: "Well thanks for all your planning help, Mr. Purvis."

Mr. McGhee: "I really don't have that much more to say. As a matter of fact, some of you in the audience actually attended our first annual award reception. I've thanked the Planning Committee and the Board, as our Chair has, for all the work that they did to make that a

very successful event. I will say one of the reasons that we, as a Board wanted to do that, is because we feel that people who are providers in the community don't always get the recognition for the hard work that they do, and they sure don't get the compensation for it. So we felt that, it was a priority of ours as a Mental Health Board to reach out and award those organizations.

There was a competitive process. We sent out probably over 160 questionnaires, and there was a methodology of going through them, talking about what each organization did. And we're very happy that people responded like they did. And we just want to say that we're taking this month off, but starting July we're going to be in our planning stage for next year because our goal was to continue to make it bigger and better, and continue to get that outreach to the community at large. And I'm not talking about the community so much in mental health, but those who are outside the mental health community, that need to be aware of the needs of the mental health community. So I just want to say thank you very much, and I want to thank those who came, and we'll look forward to seeing a lot of you next year."

Dr. Turner: "Okay, next is Item 4.4, report by members of the Board on any activities recently on behalf of the Board. Does anyone have a report?

4.4 Report by Members of the Board on Their Activities on Behalf of the Board.

Mr. Keys: "Yes, James Keys. I completed my program review of Larkin Street Youth Services. Also next week I believe on June the 20th, I believe that's a Wednesday, at 12 noon on the City Hall steps we're going to have a press conference for the budget, where we're going to talk about the cuts and the budget that was proposed by this administration, and what the Board of Supervisors can do to help not make that a reality. We would really appreciate having people come and support us next Wednesday, June the 20th at 12 noon at City Hall. We're going to be fighting for the General, Hospital psychiatric beds. We're going to be fighting for the \$1 million cut that was made for psychiatric beds. We will be then going up into the Board of Supervisors Budget and Finance Committee meeting, and doing public comment."

Ms. Brooke: "I just want to announce that I believe June 21st at 11:00 a.m., is when the Mental Health budget will be heard in the Board of Supervisors. This is another chance to have your voices heard. Just move into City Hall for next week and advocate."

Dr. Turner: "Okay. We are at Item 4.5 New Business: Suggestions for future agenda items that will be referred over to the Executive Committee. We are not allowed to discuss them now but we're allowed to name them."

4.5 New Business

Mr. Keys: "I would like to see the letter that Vice-Chair McGhee suggested."

Dr. Turner: "Okay, that's going to be real immediate, and we'll send it to all Board members on email and people can give feedback, comment, and edit suggestions. So people who are going to send us material, if you can do it by the end of the day tomorrow it would be great. I think we can put all of our concerns into one letter and address them clearly. It might be a little long letter but that's okay."

Dr. Moses: "For the Executive Committee consideration, I'd like to see if we can invite Jeff Adachi, Public Defender, to come and talk about the wonderful program he has in expunging criminal records."

Dr. Turner: "Okay, thank you. We've got that noted for the record. Any additional things for us to consider? Okay, is there any public comment relevant to this item where we talked about new business? And then there's going to be another opportunity for public comment about anything before we close."

4.6 Public Comment to Item 4.0

Member of the Public: Hi, my name is Sheri Erlinson. I am going to be encouraging at Citywide all the patients who do not want PES to close the hospitals and stuff. I will hold a petition and bring it down to you guys and then next Wednesday or Thursday, whenever the public meeting is. I will bring a group of Citywide people."

Member of the Public: "My name is David Keck. I'm interested in helping out. I'm new at all this, and I heard yesterday or recently that petitions, where you get signatures, is effective. And my question is what do you find, as a Board, to be the most effective means, a single letter, a letter accompanied by 500 signatures, 100 signatures? What does it take or what would you recommend?"

Mr. Keys: "A letter followed by a petition with a statement at the top of the petition stating what your intentions are. On the petition it should have a name, address, telephone number and signature. They should, you know, generally be voting members of San Francisco, but it doesn't actually have to be. You do want to send a copy to each and every member of the Board of Supervisors, and to the Mayor's Office and, if you can, you always want to get each and every one of those people to march to City Hall and make a demonstration. And you also want to alert the media to that very same march. So you get as much public attention as you can. At that point, people have to sit up and listen."

Mr. Keck: "Yes, I will do just that; and my only comment is I used to be on a board and president, and I ended up being a president of a home improvement association representing 17,000 people, and in 13 months after we first spoke of it we swam in the city's first swimming pool. Things like that. It got done and that made my life very rewarding for the time that we all spent. So I will learn from your comments."

Dr. Turner: "I thought you said you were new at this. Sounds like you have a lot of experience."

Mr. Keck: "Well I have a history, let me put it that way. I'm new to this Board's activities. Basically, my life ended in 1985. I woke up one day and I couldn't remember how to tie my shoes, and I'm recovering from that. And so starting in 2006, I became a peer support intern with CBHS. and at this point in time I'm going to try to allocate about 20 hours a week in volunteer."

5.0 Public Comment

Ms. Erlinson: "You're going to see my face a lot, often. I am proud to say that there were three of us from Behavioral Health Court that have completed training in NAMI. We were three that went over to Marin County. We went to the orientation for NAMI and we now give speeches and let people know about families that have people that have mental illnesses, and two of us are going to the Sheriff's Department next Tuesday to tell them what it's like to have a mental illness. It's called, 'In Our Own Voices.' So we're very proud to have three of us graduate, and hopefully there will be more funding to have people like us graduate from the Behavioral Health Court to go to like places like NAMI and stuff. It's a new program called "In Our Own Voices".

Mr. Keys: "Congratulations."

Ms. Kellum King: "I'd like to say congratulations to you. My son went through that program also."

Ms. Erlinson: "Thank you."

Mr. Purvis: "It is a very good program. All the feedback I've had within NAMI would indicate it's going very well. As she said, it's a brand new program."

Dr. Turner: "So if you see Judge Ballati, say thank you. Okay, is there any other public comment at this time? Okay, seeing none, public comment is closed. Is there a motion to adjourn?

Dr. Moses: "So moved."

Mr. Purvis: "Seconded."

Dr. Turner: "All right. The meeting is adjourned."

Ms. Brooke: If anybody wants to email any comments I'm going to bring my card down, and you can email me."

Adjournment

Meeting adjourned at 8:30 p.m.





SAN FRANCISCO MENTAL HEALTH BOARD

Gavin Newsom
Mayor

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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, July 11, 2007

City Hall

One Carlton B. Goodlett Place

2nd Floor, Room 278

6:30 p.m.

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CALL TO ORDER

ROLL CALL

AGENDA CHANGES

Item 1.0 DIRECTORS REPORT

For discussion.

1.1 Discussion regarding Community Behavioral Health Services Department Report, a report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.

1.2 Public comment relevant to Item 2.0

Item 2.0 UPDATE ON BOARD ACTIVITIES AND DISCUSSION OF FUTURE GOALS

For discussion.

2.1 Presentation: Update on the current year, discussion of the public hearing held on June 13, 2007 on the annual update for the MHSA Plan, and discussion about future meetings.

2.2 Board discussion of possible Board responses to the presentation.

2.3 Public comment relevant to Item 2.0

Item 3.0 ACTION ITEMS

For discussion and action.

3.1 Public comment relevant to Item 3.0

3.2 Proposed Resolutions

3.2.a PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of June 13, 2007 be approved as submitted.

Item 4.0 REPORTS

For discussion and possible action.

4.1 Report from the Executive Director of the Mental Health Board.

4.2 Report of the Chair of the Board and the Executive Committee.

4.3 Report by members of the Board on their activities on behalf of the Board.

4.4 New business - Suggestions for future agenda items to be referred to the Executive Committee.

4.5 Public comment relevant to Item 4.0

Item 5.0 PUBLIC COMMENT

Members of the public may address the Mental Health Board on any items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board.

ADJOURNMENT

DISABILITY ACCESS

1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Edwin Batongbacal at (415) 255-3446 (voice) or (415) 255-3449 (TTD). Five days notice before the meeting will help to ensure the presence of an ASL interpreter or sound enhancement system. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.

2. Meetings are held at City Hall, One Dr. Carlton B. Goodlett Place (between Grove and McAllister), in Room 278. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San

Bruno, 47 Van Ness, and 71 Haight/Noriega. Also, the J, K, L, M, and N lines underground. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.

3. Special Hearings are held at the Department of Public Health, 101 Grove Street, 3rd Floor, Room 300. The same public transportation options as above apply. It is wheelchair accessible.

3. City Hall is accessible to wheelchairs. Elevators, doorways, restrooms, and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on One Dr. Carlton B. Goodlett Place.

4. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City accommodate these individuals.

POLICY ON CELL PHONE, PAGERS, AND ELECTRONIC DEVICES

The ringing of and use of cell phones, pagers, and similar sound-producing electronic devices are prohibited at this meeting. Please be advised that the Chair may order the removal from the meeting room of any person(s) responsible for the ringing or use of a cell phone, pager, or other similar sound-producing electronic devices.

KNOW YOUR RIGHTS UNDER THE SUNSHINE ORDINANCE

Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review. For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact:

Frank Darby
Sunshine Ordinance Task Force
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689
Telephone: (415)554-7724
Fax: 4(15) 554-5163
E-mail: sotf@sfgov.org

Citizens interested in obtaining a free copy of the Sunshine Ordinance can request one from Mr. Darby or by printing Chapter 67 of the San Francisco Administrative Code from the internet at: www.sfgov.org/sunshine.htm

To view Mental Health Board agendas and minutes, you may visit the MHB web page at: www.sfgov.org/mental_health. You may also go to the Government Information Center at the Main Library at Larkin and Grove in the Civic Center. You may also get copies of these documents through the MHB office at 255-3474.

Lobbyist Registration and Reporting Requirements

Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance [SF Campaign & Governmental Conduct Code 2.100] to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; web site www.sfgov.org/ethics.

SAN FRANCISCO MENTAL HEALTH BOARD



Gavin Newsom
Mayor

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UNADOPTED MINUTES

Mental health Board
Wednesday, July 11, 2007
City Hall, Room 278
San Francisco, CA 94102

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BOARD MEMBERS PRESENT: James L. McGhee (Vice-Chair); James Shaye Keys (Secretary); Bridgett Brown; Jeanna Eichenbaum, L.C.S.W.; LaVaughn Kellum King; Toye Moses, Ph.D., M.P.H.; Jagruti Shukla, M.D, M.P.H ; Lisa Williams; Virginia Wright.

BOARD MEMBERS ABSENT: Rebecca Turner, Ph.D. (Chair); John Kevin Hines; Claudia Lebish; Tom Purvis.

OTHERS PRESENT: Helynna Brooke (MHB Executive Director); Ayana Baltrip-Balagas (MHB Administrator); Alice Gleghorn, Ph.D, Deputy Director, CBHS; Ruben De La Pena, SHEC; Taryn Harrington, Member of the Public; Ellie Hoecker, S.F. Human Rights Commission; Emeric Kalman, Member of the Public; James McClendon, Health & Wellness Action.

CALL TO ORDER

The meeting was called to order at 6:32 p.m. by James L. McGhee (Vice-Chair).

ROLL CALL

Ms. Brooke read the roll.

Mr. McGee: "I am conducting the meeting tonight in place of Dr. Turner who is on vacation in Japan."

Item 1.0 DIRECTORS REPORT

Mr. McGhee: "Item one on the agenda tonight is the Director's Report and we have Dr. Alice Gleghorn, Deputy Director of Community Behavioral Health Services (CBHS) to give the report."

Monthly Director's Report
July 11, 2007

1. **Budget Update:**

The Board of Supervisors reviewed the Budget as submitted by the Mayor and on June 29, 2007, restored many of the original "cuts" that were submitted and added in some additional projects or services to fund. The highlights of **restorations** and additions to the General Fund (GF) for Behavioral Health Services includes the following:

<u>New Funding Category</u>	<u>GF non-GF</u>	
Culturally Competent Syringe Exchange for Women in the Mission:	\$75,000	
Housing and Case Management for LGBTQQ Homeless Youth:	\$75,000	
Methadone Treatment Services for Homeless Women in Tenderloin:	\$184,445	
Psychiatric Services for the Homeless:	\$350,000	
Renovations Costs for Clean and Sober Facility in the Castro:	\$50,000	
Restored Substance Abuse Reductions:	\$1,800,000	
School Health and Wellness Centers (via DCYF) (non-GF):	\$320,000	
Transgender Service Project (bridge funds with Grant transfer)	\$150,000	
Restored BOS add-backs cut by DPH FY05-06 and 06-07:	\$2,845,597	\$82,871
Residential Services for Children's Mental Health	\$140,000	\$280,500

In addition, the Board restored \$4 Million in AIDS services that were reduced because of Federal cutbacks; these services include mental health and substance abuse services.

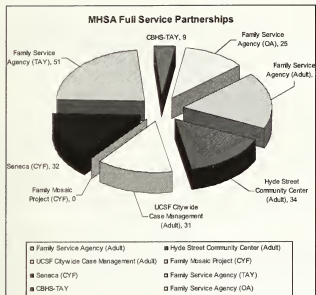
Two major items were not restored: the psychiatric inpatient beds at SFGH which will be defunded to support the creation of a community based Urgent Care Center with Acute Diversion Unit beds, and support for Buster's Place, a drop-in center on 13th Street that replaced some of the services formerly offered at the Macmillan Drop-in Center.

2. **Mental Health Service Act (MHSA) Update.**

COMMUNITY SERVICES AND SUPPORTS (CSS)

Full Service Partnerships (FSPs):

221 partners have been authorized to receive full service partnership services as of close of business on June 29, 2007. The chart and table below show the age group of these partners and the agencies where they were referred:



AGENCY	Total
Family Service Agency (Adult)	39
Hyde Street Community Center (Adult)	34
UCSF Citywide Case Management (Adult)	31
Family Mosaic Project (CYF)	0
Seneca (CYF)	32
Family Service Agency (TAY)	51
CBHS-TAY	9
Family Service Agency (OA)	25
Total	221

MHSA – Housing Service Partnerships (HSP):

Of the twenty-one (21) stabilization units available for FSPs, eighteen (18) are occupied through June 29, 2007. Four Adult partners have recently moved into permanent housing units.

Six Transitional Age Youth partners are in permanent housing.

General Systems Development:

The total numbers for unduplicated clients will be available for the fourth quarter on July 31, 2007. The total number of unduplicated clients served through the end of the third quarter is 673.

MHSA Implementation Progress Report :

We submitted the Implementation Progress Report to the State on June 29, 2007, which included public comments from the Mental Health Board meeting of June 13, 2007. There was a discussion over the terminology, outcomes, and the role of the Mental Health Board regarding the planning and implementation process. Additionally, the effectiveness of the outreach and promotion of the public comment process, itself, was questioned, as well as how best we might transform our current services to fit the wellness-recovery model. Tables illustrating budget allocations and programs and services funded were also suggested as being a useful tool. To view this report, please visit our website at

<http://www.sfdph.org/Prop63/docs/MHSAImplementProgressRpt12312006B.pdf>

Fiscal Year 2007-2008 Growth Fund Budget:

We recently requested an amendment to our performance contract to continue the expansions that we've started this year and add a new program using the fiscal year 2007-2008 Growth Fund Budget.

WORKFORCE EDUCATION AND TRAINING:

The latest Workforce Development Education and Training Committee meeting was held on June 28, 2007. The State has delayed publication of the final guidelines until early July. The committee will reconvene to review all recommendations, to insure that they are still within the framework of the final guidelines. They will then constitute the basis of our three-year plan, to be submitted to the State for approval.

MENTAL HEALTH ASSOCIATION FOCUS GROUPS

The Mental Health Association of San Francisco held focus groups with two MHSA funded agencies. These focus groups were developed to gauge how MHSA funded agencies are proceeding with their implementation and determine how the principles of MHSA have been integrated into their service delivery systems. The focus groups revealed a need for more education about MHSA to service level staff, which we are addressing with MHA-SF.

MHSA Contacts:

Upcoming Meetings: Kathleen Minioza, 255-3585, kathleen.minioza@sfdph.org

Trainings: Toni Rucker, 255-3522, toni.rucker@sfdph.org

MHSA Questions: Maria Iyog-O'Malley, 255-3551, maria.iyog-omalley@sfdph.org

MHSA ADVISORY COMMITTEE MEETINGS:

The Mental Health Services Act Advisory Committee meets bi-monthly from 3-5pm, alternating between advisory meetings and community forums. The schedule of upcoming meetings is as follows:

Wednesday, August 29, 2007
Community Forum
Location to be determined

Thursday, October 25, 2007
Advisory Committee Meeting
1380 Howard St, 4th Floor Conference Room

3. Community Behavioral Health Services (CBHS) Integration.

Zialogic will be meeting with Change Agents on Friday, July 20th from 8:30am to 2:30pm at the Ba'Hai Center, 170 Valencia Street, between Duboce and McCoppin Streets. If interested, please RSVP with Lucy Arellano at 255-3687 or lucy.arellano@sfdph.org.

4. **Comings and Goings:**

Tina Yee, CBHS Director of Cultural Competency and Client Relations is retiring after 24 years of service and commitment to San Francisco Department of Public Health. Tina has helped to promote and advance the work of cultural and linguistic competency and client empowerment here at CBHS. *We wish you well Tina!*

John Daley from CBHS Budget and Operations is retiring after 30 years of service to the Department of Public Health. John has held numerous roles, beginning his work at San Francisco General Hospital Psychiatric Emergency Services and ending his tenure at CBHS Budget and Operations. *Good luck John!*

5. **Other Upcoming Events:**

Safe Workplace Violence Prevention by Mike Arraji – August 31, 2007 (AM and PM sessions), Philip Burton Federal Building. Limited seating available.

To register for these trainings, please contact Norman Aleman, CBHS Training Coordinator at 415-255-3553 or email norman.aleman@sfdph.org

Past issues of the CBHS Monthly Director's Report are available at: <http://www.dph.sf.ca.us/CBHS/default.htm> To receive this Monthly Report via e-mail, please e-mail kathleen.minioza@sfdph.org

Dr. Gleghorn: "I will briefly summarize the report that you all have in front of you, and I am more than happy to take questions as we go along, or at the end of the report. Dr. Cabaj, apologizes for not being here tonight. He's at the mental health directors meeting in Sacramento.

The biggest item in the report is the update on the budget. It has been kind of a rocky road for the last couple of months; however the vast majority of items we were concerned about have been restored.

The list in front of you shows items that were ultimately funded through general funds. There were a few things that were not funded through these dollars, but a number of services that had been cut are back in place. That's good news all around.

The Transgender Services Project received a \$150,000 of general funds to bridge these services until SAMHSA transfers some grant funds to DPH.

Are there any questions on items that are of concern to you?"

Mr. Keys: "I don't see any funds allocated for the psychiatric beds at San Francisco General Hospital (SFGH)."

Dr. Gleghorn "The psychiatric beds at San Francisco General Hospital were de-funded, and I believe this is all part of the opening of the new Urgent Care Center."

Mr. Keys: "This situation deeply concerns me, particularly with the prospect of putting extra burden on the police. I'm especially concerned that the police will not be able to help the person experiencing a critical episode, and that person may not get the proper help or be taken to a clinic that can help them out. What's going to happen to that person? Are they going to be discharged? Are they going to be taken to jail? I'm very concerned. Also, the closing of Buster's Place after being open for just a few months is just heartbreaking. I

remember hearing Supervisor Ammiano say they are going to try to find funds to keep Buster's Place open; and we are still getting a lot of calls at Supervisor Daly's office asking that we fight to save this service.

I think overall, that the department has done a very good job, but these are two things that really concern me."

Dr. Gleghorn "Has the Board had a presentation from the people who are opening the Urgent Care Center? That might be something you would be interested in. My understanding is that it's going to be managed by the Progress Foundation with CBHS. The same people who were running the psychiatric inpatient services are going to be involved in the Urgent Care Center as far as I know. So, it might be a good idea to get the people who are running the new services at a meeting to get their input."

Mr. Keys: "Vice Chair McGhee, is this something we could bring up in new business?"

Mr. McGhee: "Yes."

Ms. Brooke: "The Board wrote a letter to the Board of Supervisors and Dr. Katz concerning this. What we're hearing at the Police Crisis Intervention Training is that there are continual red alert calls, and that there is so much overcrowding at the hospital that they don't know where to put people. The Board felt there's nothing wrong with urgent care centers, but didn't want to cut beds at SFGH.

Another issue of concern mentioned dealt with whose going to make these decisions in the street."

Ms. Eichenbaum: "Are the transgender funds going to be through API?"

Dr. Gleghorn: "My understanding is the funds would go to DPH, and then be subcontracted to API. I'm not sure if this has gone through yet."

Ms. Eichenbaum: "I'm very happy the City has chosen to do this; so, on behalf of the community, thank you."

Dr. Gleghorn: "Thanks for your help in putting that together."

Dr. Moses: "What will happen once the psychiatric beds at SFGH are de-funded? If there are no alternative services in place, people may end up on the street."

Dr. Gleghorn: "There is generally a transition period for any program closure. Any patients being carried under a particular string of funds will be transferred to another, whether it is Psychiatric Emergency Services (PES), or Buster's Place. We've been working with Buster's Place over the last month to see if we can identify patients we can move into other services like our Full Service Partnerships, and get them into more stable housing situations."

Dr. Moses: "What kind of impact will the closures have on the patients?"

Dr. Gleghorn: "It's better not to have to end the services to the patient, but when this does happen, we work very closely with them to get other services in place. This is not an easy transition, but everyone does work hard to make it as easy as possible."

Dr. Moses: "Would you please ask Dr. Cabaj to update us on this issue at our next meeting?"

Dr. Gleghorn: "He'll be here next month to give you an update."

Mr. McGhee: "How many patients are we talking about?"

Dr. Gleghorn: "I don't know the number of beds affected at PES."

Ms. Brooke: "Twenty-two. At this point there is the African American Unit, the Asian American Unit, the Hispanic Unit, the Women's Unit, and the Lesbian Gay Bisexual Transgender (LGBT) Unit. To my knowledge there hasn't been a decision made as to which of the units will be closed or whether they will take some beds from each one, or how they will do it."

Dr. Shukla: "I think it would be useful to hear from someone from this new Urgent Care Center to discuss specifically what types of resources they will have for the psychiatric patients. Having worked in a lot of urgent care clinics, I know that they see a variety of urgent care issues. They are not completely dedicated to psychiatric services. There is a PES team that can come in anytime someone is acutely ill, and it seems like they have a bed in case they have to keep someone overnight to stabilize them. This is completely different from an in-patient psychiatric service where they have a full staff – nursing, case management, psychiatrists – fully attending these patients when they stay far beyond the point to where they are stabilized."

Dr. Gleghorn: "I believe this is psychiatrically focused urgent care."

Mr. Keys: "Is there talk about housing support for people with mental health concerns around this issue?"

Dr. Gleghorn: "One of the Mental Health Services Act (MHSA) initiatives is supportive services for housing. We have funding for adult, older adult, and transitional youth programs through three different agencies, Hospitality House, Larkin Street Youth Services, and Curry Senior Center. These services are targeted toward people who are not in Full Service Partnerships, and who are trying to get into housing, or need help maintaining their housing because they are at risk of eviction. This falls under category funding for people with a mental health concern, but they would not have to have a particular class of diagnosis."

Mr. Keys: "Who is funding this again?"

Dr. Gleghorn: "It's the Mental Health Services Act funding, so it all comes through us, Community Behavioral Health Services (CBHS). These are new programs that are coming on line, and they are doing great work. There is some flexible funding involved that can help people with necessities."

Ms. Brown: "There is a report about housing support services."

Dr. Gleghorn: "That's different. I was talking about the housing services support. Let's move to the next item in the Director's Report, the Mental Health Services Act updates."

We have 221 people in Full Service Partnerships (FSPs). We opened two more FSPs than planned, so that number is higher than we had hoped to have at this time, and we are very happy about this. Associated with the FSPs, we have the Housing Service Partnership (HSP). This is geared to getting people in the FSPs into permanent housing. We have two components of the HSP:

1. Stabilized Housing: We actively help people with the paper work and walk them through all the steps needed to get them ready to move into permanent housing.
2. Permanent Housing.

Of our 21 stabilization units, we have 18 occupied, and we have qualified four people to move into our permanent units."

Ms. Brown: "Are people helped with their security deposit as well?"

Dr. Gleghorn: "Yes. And then we have six transitional age youth in permanent housing, and our four adults are seniors."

Ms. Brown: "Where do people sign up? Do they have to be discharged from a hospital?"

Dr. Gleghorn: "They have to be part of our FSPs. These are all listed at the top of the second page of the report. I can get you flyers containing brief descriptions of all the agencies for the next meeting."

Ms. Wright: "What are the ages of the transitional age youth?"

Dr. Gleghorn: "16-24 years. There are some limits on the housing. At some point people move into adult housing. It wouldn't be appropriate to have a 24-year old in the same housing as a 16-year old."

We posted the implementation progress report last month, which documented everything we have done over the last year, and the Mental Health Board's input was incorporated in the final document sent to the State.

We are continuing the expansion of programs through the Growth Fund budget. We will be adding a program focusing on violence and developing more comprehensive responses departmentally to acts of violence.

Workforce Education and Training is in the planning process. We have to work with the State and their guidelines and deadlines for all the different types of money, and unfortunately, the State has been slow in releasing their guidelines, deadlines, and funds. One of the programs we are moving forward with is the Workforce Education and Training. We had started our planning process for this program, but now we are somewhat on hold. The State was supposed to have the guidelines out in June, but they still haven't been released. They may be published in early July. The other issues are prevention and early intervention, but their implementation keeps getting pushed back.

We wanted to be proactive in developing the community process around these initiatives. We got started a couple of months ago, thinking we would be able to wrap everything up by early June and submit our plan and move forward, but we are still waiting on the State. I'm postponing structuring any other planning processes because I don't want us to get stuck every time. We will keep you informed. We are going to wait for the final guidelines and see how they stack up against the recommendations that the committee has come up with, and create a final version."

Ms. Wright: "Is the education and training for adults and youth?"

Dr. Gleghorn: "It's for everyone – educating the workforce on the recovery model; helping develop a new workforce; educating high school students on the mental health field and careers so that we can start to build a broader-based workforce. There have been many great ideas that have come up in this committee covering training family members, training existing staff, and developing new staff. Unfortunately, there is not a lot of money involved, a couple of million dollars."

Ms. Kellum King: "I served on that committee, and there was also talk about funding people with bachelor degrees to get their Master's. They did want to make sure families were involved, and using school children as peers was also discussed. Will there be additional meetings?"

Dr. Gleghorn: "Once the state guidelines come in, there will be one more meeting.

We have been working closely with the Mental Health Association (MHA). They've been holding focus groups on some areas that had been identified in the planning process. The groups looked at how agencies who are receiving MHSA funding are integrating the principles of the Mental Health Services Act in respect to service delivery.

Some of the results indicated a need to learn more about the MHSA for service-level staff: What is the recovery model? What are the tenets of MHSA? How are we hoping this will transform the system? How do we get there? Having the MHA conduct these focus groups is part of our first steps in the process.

If you have any questions about any of our upcoming meetings or trainings, or about MHSA, the contact people are listed in the Director's Report.

We have our next Advisory Committee meeting on August 29th and it will be a community forum. We haven't determined the site yet."

Dr. Shukla: "Could you elaborate more about the focus groups who revealed the need for more education about MHSA on the service level? What does that mean?"

Dr. Gleghorn: "I believe that at the management or the executive director level, people gave pretty accurate responses, but people who have direct service delivery responsibilities, like case managers and counselors, weren't really familiar with the ideas behind the MHSA, or familiar with the services being funded by MHSA, and that they were different from what had been going on before. It would be very important for these people to understand the MHSA.

CBHS integration efforts continue. We had a visit with Zialogic on Monday who met with our substance abuse and mental health access services, the TAP program, and ACCESS, as well as other groups with the CBHS administration, to move forward with integrating substance abuse and mental health services. They are also going to be meeting with the Change Agents on July 20th. There has been a lot of progress with substance abuse and mental health programs, learning about each other's fields, and developing partnerships. The initiative is doing very well."

Dr. Moses: "Are there any Full Service Partnerships with any agencies in the Bayview/Hunter's Point area?"

Dr. Gleghorn: "All the FSPs were awarded through a Request for Proposals (RFPs) process. Except for Family Mosaic and CBHS's TAY programs, the community-based agencies shown in this report were the ones who successfully had their RFPs accepted. I can't recall if Bayview/Hunter's point submitted a bid. Unfortunately, we were not able to fund as many programs as we would have liked, but the FSPs draw from programs all around the city."

Dr. Moses: "The fact that there are no FSPs in Bayview/Hunter's Point, a very important part of the city, is concerning."

Dr. Gleghorn: "We did have a number of members from the Mental Health Board participate in the RFP review process, and these were the agencies that came out on top.

I haven't seen a lot of RFPs that focus on a particular neighborhood. It's more common for them to focus on a particular population. In this instance, there were so many populations identified in the planning process that the RFP was written in a very broad way. It didn't zero in on any particular population or neighborhood. If we get more money from the

State, we could then look at our needs and see if we could make a recommendation to focus on particular areas."

Dr. Moses: "I just am upset that this area of the city is not being taken care of."

Dr. Gleghorn: "Although there isn't an FSP, with the exception of Family Mosaic in the area, there are a lot of activities that are beginning to happen over there. I have a couple of projects with Southeast and Bayview, and there are some health initiative partnerships beginning to be developed with Bayview and Southeast Health Center."

Dr. Moses: "The Bayview Foundation used to provide services. Maybe they didn't apply."

Dr. Gleghorn: "I don't recall if they applied."

1.1 Public comment relevant to Item 1.0

There was no public comment.

1.2 Director's Report: Board Discussion

Ms. Kellum: "Violence prevention in the workplace was mentioned, but right now in the Visitation Valley area, it's almost like a blood bath. The other day, right around the corner from where I live, some young men ran up and shot a young man sitting in a van in broad daylight. A family watched that in horror. I'm concerned that this is not being addressed. This is getting really serious. I'm concerned about coming home at night. There are tennis shoes being hung on telephone wires. This is a signal that means that drugs can be bought in this area. I've called the fire department who says call PG&E, whose says call cable. I also called 311. Now there are four pairs of tennis shoes. We shouldn't have to live this way. I know they have implemented some injunctions in Bayview, but something has to be done in Visitation Valley soon. There are going to be more killings before it stops, and I have a son; and I am concerned. I'm really concerned.

I'm asking here tonight who knows what channels to take, and what can we do? This is no way to live."

Ms. Brown: "How long has Family Mosaic had the contract? The chart shows zero clients."

Dr. Gleghorn: "Family Mosaic is a Department of Public Health (DPH) entity, so they have all the things that come along with being a civil service entity. They had delays in getting their positions approved through the civil service process. They are just getting their staff hired, and I believe they have actually enrolled some clients; but they had a late start up."

Dr. Moses: "Most of the staff positions are not civil service."

Dr. Gleghorn: "The funded ones were."

Mr. McGhee: "Thank you Dr. Gleghorn for your report."

Item 2.0 UPDATE ON BOARD ACTIVITIES AND DISCUSSION OF FUTURE GOALS

2.1 Presentation: Update on the current year, discussion of the public hearing held on June 13, 2007 on the annual update for the MHSA Plan, and discussion about future meetings.

Mr. McGhee: "Since we do not have a formal presentation, we will be discussing Board reactions to our June 13th public hearing on the annual update for the MHSA Plan and ideas for future meetings."

Dr. Shukla: "I have an observation about the conversation we just had. It seems that there may be some areas that are underserved by MHSA dollars, and areas that could potentially benefit from services, and I am wondering if it's worthwhile trying to figure out if there are areas underserved. The explanation that we've been given, is that groups didn't apply in all the different areas; but to some degree, if groups didn't apply, there may be a reason; and maybe there needs to be some engagement and outreach to the groups that are in these areas; and some assistance and support to develop programs to serve them. We're putting it out there and groups apply, and of those that apply, certain ones get the money. If certain areas aren't applying, then I think that outreach needs to be done to help those groups apply. It doesn't mean that people in these areas should suffer because groups aren't applying."

Mr. Keys: "I agree with Dr. Shukla. It also seems that larger, more established organizations are getting funded, while smaller, newer, more innovative programs may try once, and by failing to get the funding may close down, or not apply next year. We really should try to think outside of the box in trying to bring mental health services to the public. We keep seeing the same problems."

Dr. Moses: "I also agree with Dr. Shukla. The outreach is not there. If this happened in the Tenderloin or SOMA area, someone would call the health department and say that we want these people to be represented, whether proposals are submitted or not. Dr. Cabaj has come here many times, and I have continually brought up the fact that the southeast sector of the city does not have a residential program for substance abuse, and asked if he could do something before the programs submitting their proposals. What can be done to have a residential program for the southeast sector? Now here we are after the fact. I'm really concerned about this."

Mr. McGhee: "I agree with what is being said, and feel the Mental Health Board has a responsibility to take action on this matter. There are two things we could do. We could make a recommendation that from this point on, the RFPs go out to different sections in the city. I agree with Mr. Keys and Dr. Moses, that when we put out these blanket proposals, a lot of times, larger firms that have the capability, the experience, the education, and the technological access will win those contracts. And some of our communities have not historically done as well. So, to combat this kind of discrepancy, I suggest that we write a letter outlining our legitimate concerns."

The Mayor has expressed time and time again, about trying to make a difference in these areas, and I think it would be very appropriate if the Board sent a letter to the Mayor as well as a copy to Dr. Cabaj, and Ms. Garcia, and anyone else you feel should get the letter. I think the Board has to become more proactive in reference to these issues, and not tolerate the 'this is the way it gets done' explanations that come to us. I think we have to make a more proactive stance in making suggestions for changes that can affect communities that we all represent."

Mr. Keys: "I believe your idea for a letter is excellent, and I think we could enhance it by creating a resolution that has Dr. Shukla's idea, and asking the Department of Public Health to create new categories for their RFPs; so if your organization has something that is not offered by other agencies, like you have more beds or you are more culturally competent, you get one or two points more. We create this resolution and attach it to the letter and send it to the Mayor and Board of Supervisors, and see if we can get that resolution carried, and then present it to the Department of Public Health."

Dr. Shukla: "The letter is an excellent idea; however, I think before sending it, it would be helpful to actually look at these 221 people and see where they come from. We really don't have the facts right now."

We can see that there are institutions that are located in areas of concern, but we don't know the make up of the patients being served. Then we can be clearer on who is not getting served. And then I think we may want to look at the Mental Health Services Act in its totality, because this is one aspect of it and see, in its totality, if it's serving these areas or not. And if not, as a suggestion, look to who are the groups providing service in these areas – did they apply, if they applied, were they rejected or not? If they didn't apply, why didn't they apply? Maybe there can be outreach there that can say – did you know that this money was here? Did you know you could apply? And next year, because this is an ongoing annual evaluation from what I can tell – would you be willing to apply if you were to have some assistance?"

Mr. McGhee: "I would like to suggest that we do the research to get the adequate information, and then we draft a letter. If our findings come out basically as we think they will – that certain areas are being excluded, we identify discretionary funds to be allocated to the left-out communities. I would like this component to be in the letter."

Ms. Kellum: "Sometimes, some funds are placed in certain categories, or certain hands that are not honestly serving the population; but because they can go in with say, \$60,000, hire a doctor, hire a program director who takes most of the money and does a workshop with some teenagers and film it. It's not reaching the population. And what they do, I find in that area, in giving out funds, they will select a place like the YMCA, because it's known and has been there. But, what is it doing to really reach out to the community? What is it doing to address the problems? And how many YMCAs do we have in the southeast sector?"

Mr. McGhee: "Can we have a consensus that we can move forward with someone to work on this?"

Ms. Brooke: "I think we have gaps in our knowledge about this process. Maybe we can establish an ad hoc committee to look at this issue and invite speakers."

Mr. Keys: "I think that is a great idea. I think we should create a committee to actively research this from a point of which communities are being served. Where are these funds going? Create something that is viable to present to DPH."

Mr. McGhee: "Let me make a suggestion that we create this ad hoc committee to review the RFP process, and let me take the initiative to appoint four people to this committee: Dr. Moses, Dr. Shukla, Mr. Keys, Ms. Kellum King."

Let me tell you why I want you on the committee Dr. Moses. You represent the southeast sector, and you have some very strong ideas and commitment to this issue. You have insight and knowledge that a lot of us don't have."

Dr. Moses: "I will reluctantly accept, and thank you for the vote of confidence."

Mr. McGhee: "The committee can decide who will be chair."

Mr. Keys: "I think it should be three people."

Mr. McGhee: "If you only have three, and one person misses a meeting, you're down to two. This is not enough people. It was the four of you who brought up the issue."

Mr. Keys: "It's not that I don't want to serve, but I think another member should be given a chance to serve. I represent the Tenderloin. I would like other people to step forward. If they don't, I will serve on the committee."

Mr. McGhee: "Is there anyone else who would like to serve on the committee? Committees are open to everyone."

Ms. Eichenbaum: "I just would like to say, that all other things being equal, I would be very interested in serving on the committee, but I just started a new job two days ago, and this is not the right time for me to take it on. If the committee continues its work in several months down the road, I would be interested in coming aboard."

Ms. Brown: "I'm also interested, but I represent the Fillmore. If it can meet before our regular meeting, then I can do it."

Dr. Moses: "You appointed four, but five would be great."

Mr. McGhee: "There are five people who will now sit on the committee – Dr. Moses, Ms. Kellum King, Mr. Keys, Dr. Shukla, and Ms. Brown."

Dr. Shukla: "I can definitely do behind-the-scenes work, the research. I may not be able to make it here at 6:00 p.m."

Mr. Keys: "You can supply the research, and we can infer references from it and pull together recommendations."

Mr. McGhee: "We'll now move on to the Annual Report. In it we can find our outlining of the goals for the 2006/2007 year."

The full Mental Health Board Annual Report can be found at: www.sfgov.org/mental_health.

Mr. McGhee: "Are there any other areas you have looked at and would like to propose? We've heard one: have the Urgent Care Center people come. I still think that these goals already outlined are still very important."

Dr. Moses: "As part of our obligation as board members, we are supposed to monitor sites, and I don't see that reflected in the annual report."

Mr. McGhee: "It's listed here in the annual report on page four."

Ms. Williams: "What was the reason to have the District Attorney come?"

Mr. McGhee: "There was a tremendous amount of disturbances in the southeast sector of the city, and also the discrepancy in treatment of mentally ill people. This discussion of having her come was also at the time when that young mother threw her three children into the Bay and drowned them, and the District Attorney's office didn't seem to take into consideration, her mental illness. I also spoke with D. A. Harris personally about coming, and she thought it was a good idea."

Are there anymore thoughts?

There were three priorities identified at our retreat last December. They are:

Goal #1: Develop new partnerships with other organizations in order to collaborate on mental health issues.

Goal #2: Lead and participate in education and advocacy efforts in identified legislative areas.

Goal #3: Provide education to San Francisco organizations and the community about critical mental health issues.

Those were three of our priorities. What do you think? Have we been successful in accomplishing them? Do we need new ones?"

Mr. Keys: "In regard to Goal #2, I've seen other commissions, Fire, Police, and others, come up with resolutions that get more results. Their meetings are televised; they get more press; their concerns are seemingly, heard.

I believe we are lacking in that area. We should be letting DPH know about the issues. We should do the same thing as we did for the PES beds. We were very proactive. We should follow up with the Director of Public Health and have him come in to find out how the cuts are going to effect the population."

Ms. Brown: "I think we are lacking in respect to Goal #2, because every time we hear about an issue, it is after the fact. We don't hear about it when we can make a difference."

Dr. Shukla: In regard to Goal #3, educating organizations and communities about mental health issues, we have written some letters higher up to the Board of Supervisors and the Mayor. One thing that might be easy to do is copy these letters to the organizations that we honored at our awards ceremony."

Mr. McGhee: "I agree with all your comments, but I would like to say this. I personally think that this board has done a great job of following through on these goals. We're better than last year. There are times where we will always be in a reactive mode. We've taken a more proactive stance and succeeded in letting more people know about the Mental Health Board. I believe we have alerted more people to who we are quite successfully. I think we need to enhance these goals. I think we have made tremendous strides as the Mental Health Board of San Francisco.

I sit on the State of California Association of Mental Health Boards and Commissions. I find more board members around the state who say they go on our website and read our minutes, and other people come up to me and talk about what we are doing as a board.

There are 56 boards and commissions in California. There are 25 of us that were elected to the State Association. I serve as the area manager for 14 counties, and I am always hearing people discuss the good work we are doing. This is a tribute to the hard work you all have done this past year to elevate this board, and I think you should know that."

Ms. Eichenbaum: "Just to follow up on what Mr. Keys was saying in regard to Goal #2, I think one thing we might explore in the next year is having a higher profile in the community. There are a variety of ways to do that. We can look at getting more media presence at our events. The awards ceremony is something that could have been in some of the local newspapers. Also, when we have these issues that come up like what we discussed tonight concerning the southeast sector, one of us could write an op ed piece in the Chronicle or the Examiner, and that would be a way of highlighting the intersection of mental health issues and the other problems communities are experiencing.

My site visit was at the Instituto Familiar de la Raza, and I happened to go there right at the time when there was a discussion about gang warfare and violence in the Mission. Several youth had just been murdered. I thought that this was a perfect opportunity to start thinking about how the services, or lack thereof around substance abuse and mental health issues really impact on families, youth, and older adults. I think there are creative ways that we can put this more in the City's consciousness that we haven't fully explored yet."

Dr. Moses: "I just wanted to follow up on what Mr. McGhee said about how people view the Mental Health Board. Every year we go the same retreat in Burlingame, and people see how committed we are. We always show up in high numbers.

Also talking about exposure, I serve on the Immigrant Rights Commission, and the meetings are televised. Maybe we should look into seeing how we can televise our meetings. This would be good for people who cannot come to our meetings. We are making progress."

Mr. McGhee: "That is exposure. I watch the Police Commission, or the Planning Commission, and I get a sense of what's going on."

Mr. Keys: "SGTV is the City and County of San Francisco television station. We could probably write of letter to the president of the Board of Supervisors requesting that our meetings be televised."

2.2. Public Comment:

Mr. Kalman: "Maybe we could have the NAMI people who worked with the University of California and were paid through the MHSA. Maybe they could come to speak about this program.

ITEM 3.0 Action Items:

3.1 Public comment relevant to Item 3.0

Mr. Kalman: "The address for last month's meeting should be changed to 101 Grove Street.

3.2 Proposed Resolutions

3.2.a PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of June 13, 2007 be approved as submitted

Minutes approved with the address correction.

ITEM 4.0 Reports:

4.1 Report from the Executive Director of the Mental Health Board.

Ms. Brooke: "We received notification yesterday, that our budget now includes a full-time staff member. Ms. Baltrip-Balagas will be starting full time.

The next items are program reviews. We did six. Mr. McGhee did Community Vocational Enterprises, Mr. Keys did Larkin Street Youth Services, Ms. Lebish did Walden House, Dr. Moses and Ms Kellum King did Family Mosaic, Ms. Eichenbaum did Instituto Familiar de la Raza, and Dr. Turner did the Mental Health Association.

I will continue to set up other reviews, adding the MHSA programs. They will be included in our list for next year.

Of those six program reviews, I've received two summaries, and I am waiting for the other four.

I ran into Sharon Johnson today, who used to be the Chief of Staff for State Senator John Burton. An interesting thing about her is that she was a single-mother with five children who are now all grown, and she was briefly homeless years ago. After she left Senator Burton, she became the Executive Director for his homeless program that served families. She has now been hired by CBHS to develop a buddy program with Project Homeless Connect. They are learning that one of the great difficulties faced by the homeless is getting to services. This buddy system will partner people to help homeless people get to their appointments. Later on, there may be a stipend of \$11 per hour for this position.

Tina Yee has retired, and there is a retirement party for her on July 20th. Anyone is welcome to go. They have asked the Mental Health Board to subsidize some of their clients to attend the event. We have allocated up to \$300.00.

The Mayor's Office on Disability is inviting people to their 17th ADA Annual Celebration on July 26th at City Hall, starting at 11:00 a. m."

Dr. Moses: "How are we doing budget-wise?"

Ms. Brooke: "The Mental Health Board's budget? The budget is part of San Francisco Mental Health Education Funds, Inc. (SFMHEF), and we are doing very well. I will talk about that at our SFMHEF meeting following this one."

4.2 Report of the Chair of the Board and the Executive Committee:

Mr. McGhee: "We have *Family Member* and *Consumer* Seats open on the Board. We are particularly looking for Asian Americans and Hispanics to apply so that we can fully represent the people in the community and the system. Please encourage people you know to apply."

Mr. Keys: "Perhaps we can send two members from our board to go to some of the agency meetings and events, and do a presentation. We can then invite people to attend our board meetings, and perhaps even apply for a seat."

Ms. Wright: "I have contacted people I know and they asked for the application. I will follow up to see what they have done."

Mr. McGhee: "Can you get the names of the people you contacted to Ms. Brooke?"

Ms. Wright: "Yes. One of them you already sent a package to."

Dr. Moses: "In addition to that, maybe we don't have to look far, and look in our own backyard."

Ms. Brooke: "I ran into Supervisors Elsbernd and Dufty, and asked them to speak to the other supervisors to see if any of them would be interested in sitting on the Board."

Dr. Shukla: "Maybe we can send a flyer to Asian American and Hispanic organizations."

Dr. Moses: "Jeff Mori, the Executive Director of the Asian Recovery Program would be a good contact."

4.3 Report by Members of the Board on Their Activities on Behalf of the Board.

Mr. McGhee: "I've already shared my activities about working with the State of California Association of Mental Health Boards and Commissions. Also, on behalf of the Board, Ms. Brooke and Ms. Baltrip-Balagas reproduced a letter from Speaker Pelosi and framed it so that it could be presented to Dr. Horn and Assemblyman Dymally. They did a very good job."

Dr. Moses: "In addition to thanking the staff, we also have to thank you Mr. McGhee for using your influence to bring Assemblyman Dymally here, and the outgoing president of the Board of Psychology."

4.4 New Business

Dr. Moses: "There is a new director at Family Mosaic, and I think we should invite him to come and give a presentation. He is young, enthusiastic, and very good. As you know, we saved Family Mosaic from closing many years ago."

Mr. Keys: "I think we should choose a day, like a Friday afternoon or Saturday and go, as a board, on a tour of a facility. It would be a nice outing for all of us, and we could learn about a facility. We should try at least one field trip for the Mental Health Board."

Mr. McGhee: "That's a good idea, and falls under our Goal #1 and Goal #2. We could begin the process of establishing partnerships with organizations and expanding the education component. Maybe we could even expand the concept to doing a field trip on a quarterly basis or once every six months. I think it falls right in line with what we did with the May event in recognizing people in the community."

Dr. Moses: "I'm a little bit disturbed about the budget Dr. Gleghorn discussed tonight. I was wondering if we could request that Dr. Cabaj, in his next report, to present a statistical breakdown of all the services funded by CBHS, and MHSA, and the partnerships being provided to the southeast sector."

Dr. Shukla: "Bringing Family Mosaic is a good idea. One thing I was curious about that was mentioned was that the reason there was zero enrollment was because there wasn't staff that was recruited, and I would like to hear first person about this. Is it difficult to recruit staff in that area? Why the delay? Because it was difficult to recruit staff, then that's a big enough issue unto itself that needs to be addressed. Because you can advocate for funds to go to the area, but if you don't have workers, that's an issue that needs to be addressed. It would be good to get some insight into what's going on."

Bringing the Urgent Care Center in for a presentation might be better a few months down the road because at that point, they will have had a chance to get up and running, and be able to give us an idea on what they are doing. We also need to follow up on our letter and Dr. Lu's concerns."

Ms. Wright: "In regard to a Board field trip, how can we pick an organization to visit?"

Mr. McGhee: "Board members can submit organization names to Ms. Brooke that might be considered by the Board. She can then begin work on some dates and coordinate with Board members."

Dr. Shukla: "One other thought, when we have the Urgent Care Center, I think it would be interesting, not to create controversy, to have Dr. Lu come in also and give an update from the SFGH side."

4.5 Public Comment to Item 4.0

There was no public comment.

5.0 Public Comment

Member of the Public: "I was wondering about the budget update that was discussed tonight. What was the Mental Health Board expecting? How do you plan to respond?"

Mr. Keys: "What happened, is that the Mayor of the City and County of San Francisco proposed, in his budget plan, to cut services at San Francisco General Hospital, and it was decided that the cuts were to be the 22 psychiatric beds. The staff of that department opposed these cuts. When the issue was brought to the Mental Health Board, we discussed it, and set forth to make our opinion known to the Mayor, the Board of Supervisors, and Dr. Katz by writing letters. The Mayor had gone to Dr. Katz, the Director of the Department of Public Health to make these cuts. The cuts have been made, and we are concerned about the effect this action will have, not only on the system's clients, but on our emergency and police services."

Adjournment

Meeting adjourned at 8:33 p.m.



SAN FRANCISCO MENTAL HEALTH BOARD

Gavin Newsom
Mayor

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San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
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www.sfgov.org/mental_health

MEETING OF THE MENTAL HEALTH BOARD

Wednesday, August 8, 2007

City Hall

One Carlton B. Goodlett Place

2nd Floor, Room 278

6:30 p.m.

PLEASE NOTE: THERE IS NO MEETING THIS MONTH
AUGUST 8, 2007.

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KNOW YOUR RIGHTS UNDER THE SUNSHINE ORDINANCE

Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review. For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact:

Frank Darby
Sunshine Ordinance Task Force
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place

San Francisco, CA 94102-4689
Telephone: (415)554-7724
Fax: 4(15) 554-5163
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SAN FRANCISCO MENTAL HEALTH BOARD



Gavin Newsom
Mayor

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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, September 12, 2007

City Hall

One Carlton B. Goodlett Place

2nd Floor, Room 278

6:30 p.m.

CALL TO ORDER

ROLL CALL

AGENDA CHANGES

Item 1.0 DIRECTORS REPORT

For discussion.

DOCUMENTS DEPT.

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1.1 Discussion regarding Community Behavioral Health Services Department Report, a report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.

1.2 Public comment relevant to Item 2.0

Item 2.0 URGENT CARE CENTER

For discussion.

2.1 Presentation: Urgent Care Center, Liz Gray, Director of Placement, CBHS, Steve Fields, Executive Director, Progress Foundation

2.2 Board discussion of possible Board responses to the presentation.

2.3 Public comment relevant to Item 2.0

Item 3.0 ACTION ITEMS

For discussion and action.

3.1 Public comment relevant to Item 3.0

3.2 Proposed Resolutions

3.2.a PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of July 11, 2007 be approved as submitted.

Item 4.0 REPORTS

For discussion and possible action.

- 4.1 Report from the Executive Director of the Mental Health Board.
- 4.2 Report of the Chair of the Board and the Executive Committee.
- 4.3 Report from Nominating Committee
- 4.4 Report by members of the Board on their activities on behalf of the Board.
- 4.5 New business - Suggestions for future agenda items to be referred to the Executive Committee.
- 4.6 Public comment relevant to Item 4.0

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Mayor Gavin Newsom

Bob Cabaj, M.D.
Director

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Monthly Director's Report
August 8, 2007

1. **07-08 CBHS Outcome Objectives:** I am pleased to announce that this year's CBHS Performance Objective Planning Committee led by CBHS CYF Director Sai-Ling Chan-Sew completed the final document of the CBHS Performance Objectives for FY07-08. Much appreciation is deserved by all who served on the Performance Objective Committee, for staying with the process and providing valuable input and guidance, as well as data collection and analysis, towards the development of the final document. Thank you also to Karen Strickland from Golden Bear, who facilitated and wrote the drafts of the document.

One of the important changes we will implement this FY 07-08 is to conduct a system-wide evaluation to collect client level outcomes using a random sampling method for all clients receiving service from CBHS. This evaluation will be conducted jointly by CBHS Evaluation and Quality Management staff for this new fiscal year, with input from providers. This system-wide evaluation recognizes that while it may be difficult to measure specific outcome by individual providers, we need to have information on the impact of our services, collectively as a service system, on the lives of our clients.

Another significant change we made this year is to separate quality improvement objectives, from compliance objectives, and from actual performance outcome objectives. The result of this delineation is a more concise document (13 pages vs 25 pages for FY06-07).

Please let Sai-Ling know if you are interested in participating in our next planning effort for the system-wide evaluation. She can be reached at (415) 255-3439, or at sai-ling.chan-sew@sfdph.org

2. **Standby/On-call CBHS Staff Needed to Assist Families of Victims of Violence.** As you may well be aware, the needs of families impacted by violence continue to rise. Presently, we have a CBHS Violence Response Team that was created several years ago in collaboration with Community Programs and the Child Crisis Team. This Team, over the last two years, has responded to the needs of hundreds of families, including providing immediate crisis trauma support, as well as case management follow-up.

I am asking interested CBHS clinicians and other civil-service staff to volunteer to help us to respond to the needs of families impacted by violence. We especially need help during the most troubled times—evenings and weekends—and often in specific areas of the City—the Western Addition, Bayview, Hunter's Point, Visitation Valley and the Mission. We would like volunteer standby responders to strengthen the Violence Response Team's efforts, and I am seeking civil service staff who would be especially sensitive to the racial and ethnic issues for the communities at risk in these different parts of the City. Staff who have training in trauma-focused and crisis intervention training are especially encouraged to apply, though training will be provided to all of the volunteers.

Stand-by responder volunteers will be organized into a schedule that matches the needs of the community. Civil-service standby staff will receive on-call/stand-by pay and, if called in to help, receive compensation for the additional work as outlined in the particular MOU for the Union they are covered by. The on-call/stand-by will be for evenings and weekends (usually 7:00 pm to 7:00 am plus 7:00 am to 7:00 pm Saturdays, Sundays and holidays) and will be scheduled at intervals that will not disrupt the ability to work at regular job and duties.

I have asked Edwin Batongbacal, Director of CBHS Adult/Older Adult Services, to organize the volunteer efforts and he will work with Charles Morimoto, Deputy Director of Community Programs and supervisor of the Violence Response Team, and Sai-Ling Chan-Sew, Director of CBHS Children, Youth and Families Services and supervisor of the Child Crisis Team. Please contact Edwin's assistant Antonio Trink at antonio.trink@sfdph.org to express your interest (please include the name of your immediate supervisor). **Thank you for considering volunteering to help the Violence Response Team.**

We are also piloting a collaboration with Walden House to have similar standby/on-call responders to provide immediate crisis support to families and loved ones of victims of violence.

3. **Mental Health Service Act (MHSA) Update.**

MHSA Prevention and Early Intervention: The Prevention and Early Intervention Draft Guidelines have been posted to the Department of Mental Health's Website. To review the guidelines please visit http://www.dmh.ca.gov/MHSA/PEI_PlanGuidelines.asp

COMMUNITY SERVICES AND SUPPORTS (CSS)

Full Service Partnerships (FSPs):

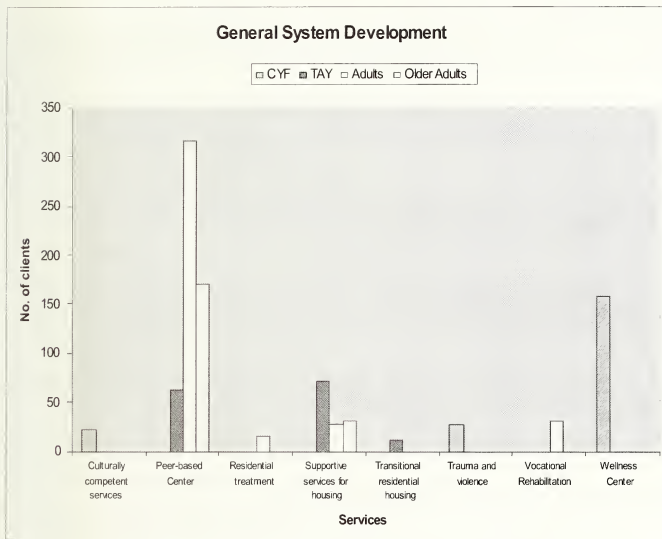
231 partners have been authorized to receive full service partnership services as of close of business on June 29, 2007. Of these, children, youth and family account for 37, transitional age youth account for 26, adults account for 83, and older adults account for 50, of the partners who are actively engaged in services. Recruitment and retention of staff, which caused delays in implementation, was the major challenge faced in the initial year of providing services. Originally, 20% of all FSP's were projected to be placed in housing. In fact, 32 were housed, falling short of the anticipated total of 39 (20% of 194). The slow transition into permanent housing was due to some clients not having proper identification and no documentation of housing history. The table below summarizes the full service partnerships of the past fiscal year:

MHSA FSP Client Information Fiscal Year 2006 - 2007

AGENCY	Age Group	Authorized	Actively Engaged	Housing Stabilization	Housing Permanent
Family Service Agency	Adult	40	34	6	3
Hyde Street Community Center	Adult	36	22	7	1
UCSF Citywide Case Management	Adult	33	27	3	2
Family Mosaic Project	CYF	0	3		
Seneca	CYF	35	34		
Family Service Agency	OA	53	50	4	
CBHS-TAY	TAY	9	0		
Family Service Agency	TAY	25	24		6
Total		231	194	20	12

General Systems Development:

There was a grand total of 960 clients served during the past fiscal year just ended. This number accounts for Children, Youth , and Families (210), Transition-aged Youth (154), Adults (393), and Older Adults (203). The adult population accounted for more than 40% of all clients served, and includes such programs as Vocational Rehabilitation (32), Supportive services for Housing (28), Peer-based Center Services (317), and Residential Treatment (16). For further information regarding services and population served, please consult chart and table below.



General System Development
Fiscal Year 2006 - 2007

Services	CYF	TAY	Adults	Older Adults
Culturally competent services	24			
Peer-based Center		63	317	171
Residential treatment			16	
Supportive services for housing		73	28	32
Transitional residential housing		12		
Trauma and violence	28			
Vocational Rehabilitation			32	
Wellness Center	158			
Total	210	148	393	203

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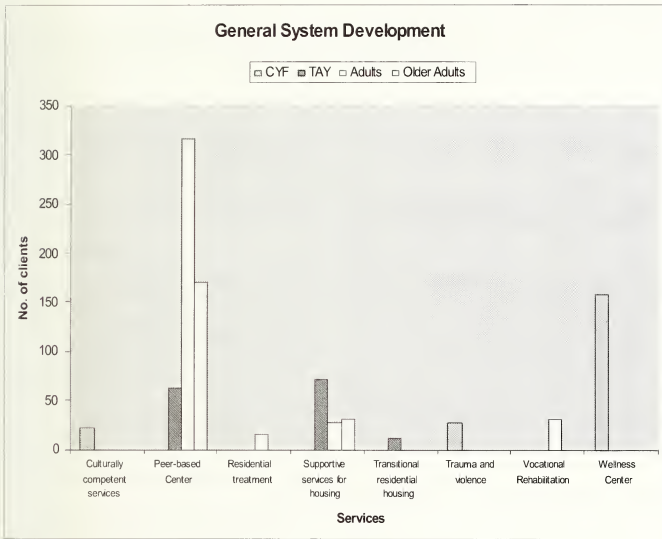
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Total	210	148	393	203

MHSA ADVISORY COMMITTEE MEETINGS:

The Mental Health Services Act Advisory Committee meets bi-monthly from 3-5pm, alternating between advisory meetings and community forums. The schedule of upcoming meetings is as follows:

Wednesday, August 29, 2007
Community Forum
Location to be determined

Thursday, October 25, 2007
Advisory Committee Meeting
1380 Howard Street, 4th Floor Conference Room

4. Other Upcoming Events:

PERINATAL SUBSTANCE ABUSE: Motivating Patients (and Providers) for Change – Friday, September 21, 2007, 8:30 am – 1:00 pm @ Hiram W. Johnson State Building Conference Center, Ken Saffier, MD, Addiction Medicine Specialist.

ANNUAL CBHS SYSTEM ORIENTATION - Thursday, September 27, 2007, 8:30 am - 12:30 pm @ Ba'Hai Center, 170 Valencia Street. This annual training is designed to provide CBHS, DPH and other county department personnel, both clinical and administrative, with an overview of CBHS mental health and substance abuse services. This is an excellent orientation for newer staff and interns. Come learn about what services are available, how to access them, consumer involvement and an introduction to administrative requirements. To register for this event, fax your name, organizational affiliation, e-mail and/or fax number to (415) 252-3057. Or for more info, call (415) 255-3553.

A FORUM ON THE RECOVERY MODEL AT WORK IN CBHS - Friday, September 28, 9:00 am - 12:15 pm @ Ba'Hai Center, 170 Valencia Street. Keynote Speaker is Bob Cabaj, MD, CBHS Director. Moderator: Jennifer Baity Carlin, LCSW, of San Francisco Behavioral Health Center. Celebration of Recovery Month to follow at Glide Memorial, 330 Ellis St., @ 2:00 pm

To register for these trainings, please contact Norman Aleman, CBHS Training Coordinator at 415-255-3553 or email norman.aleman@sfdph.org

Past issues of the CBHS Monthly Director's Report are available at: <http://www.dph.sf.ca.us/CBHS/default.htm> To receive this Monthly Report via e-mail, please e-mail kathleen.minioza@sfdph.org



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2nd Floor, Room 278

6:30 p.m.

CALL TO ORDER

09-10-07P03:39 RCVD

ROLL CALL

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AGENDA CHANGES

SEP 10 2007

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4.2 Report of the Chair of the Board and the Executive Committee.

4.3 Report by members of the Board on their activities on behalf of the Board.

4.4 New business - Suggestions for future agenda items to be referred to the Executive Committee.

4.5 Public comment relevant to Item 4.0

Item 5.0 ELECTION OF OFFICERS FOR 2007 to February 2008

For discussion and action.

5.1 Public comment relevant to Item 5.0

5.2 Report from Nominating Committee

Rebecca Turner, PhD is resigning from the Mental Health Board and therefore, resigning as Chair. The Executive Committee selected Toye Moses, PhD, Chair, Bridgett Brown, and Lisa Williams to be on the Nominating Committee. The committee met on August 29, 2007. The officers elected this evening will hold their positions until February 2008 when the bi-annual election will take place.

5.3. PROPOSED ACTION: Election of Officers.

The Nominating Committee selected James L. McGhee for the position of Chair. As this leaves vacant the position of Vice-Chair, the Nominating Committee selected

Jagruti Shukla, MD, for the position of Vice-Chair. Nominations can also be made from the floor.

Item 5.0 PUBLIC COMMENT

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SAN FRANCISCO MENTAL HEALTH BOARD

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UNADOPTED MINUTES

Mental health Board

Wednesday, September 12, 2007

City Hall, Room 278

San Francisco, CA 94102

DOCUMENTS DEPT.

OCT - 4 2007

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BOARD MEMBERS PRESENT: Rebecca Turner, Ph.D. (Chair); James L. McGhee (Vice-Chair); James Shaye Keys (Secretary); Bridgett Brown; John Kevin Hines; Claudia Lebish; LaVaughn Kellum King; Toye Moses, Ph.D., M.P.H.; Tom Purvis; Jagruti Shukla, M.D, M.P.H.; Lisa Williams; Virginia Wright.

BOARD MEMBERS ABSENT: Jeanna Eichenbaum, L.C.S.W.

OTHERS PRESENT: Helynna Brooke (MHB Executive Director); Ayana Baltrip-Balagas (MHB Administrator); Bob Cabaj, M.D., Director, CBHS; Pam Fischer, NAMI; Steve Fields, Progress Foundation; John Nickens, M. D., Progress Foundation; Erin Williams; Progress Foundation.

CALL TO ORDER

The meeting was called to order at 6:32 p.m. by Rebecca Turner, Ph.D. (Chair).

ROLL CALL

Ms. Brooke read the roll.

Item 1.0 DIRECTORS REPORT

Dr. Turner: "Item one on the agenda tonight is the Director's Report and we have Dr. Bob Cabaj, Director of Community Behavioral Health Services (CBHS) to give his report."

Dr. Cabaj: "It's been a while with the break in the summer to be able to come back here and review the budget year. You should have a written report in front of you, and again, I'll just walk through some of the highlights.

The first news item was actually updated 30 minutes ago. There was a big delay in the budget. The Assembly and the Senate had worked out a huge compromise and they ultimately agreed to keep AB 2034. The Governor, supposedly said he would keep AB2034, but when he signed the budget, he blue penciled AB 2034 and cut it. So there was a major uproar, as you can imagine, and a lot of us started working behind the scenes. There is going to be again another set of protests, but they thought it's best to try to find some fiscal solution.

The Governor had basically said AB 2034 is a good program, but too bad. He didn't quite say it that way but that's what the message was. And he said we could use other funding sources, even the Mental Health Services Act (MHSA), and then we had been told that it would be illegal to use MHSA funds. That it would be supplantation. There was a big struggle about this.

Well just about 30 minutes ago, we got a notice that there is a secret MHSA fund. What we've been hoping for the last two weeks is that there's a secret fund of Mental Health Services Act dollars that haven't been expended yet that was under the administration of the Department of Mental Health, and they agreed to release \$64 million of that to cover AB 2034 cuts. They're going to amend the language of the bill so that the money will be allowed to be used. In other words, because of the problem of using Mental Health Services Act dollars, they're going to be able to define it as continuing expansion so it won't somehow qualify as supplantation. The details will follow but that's very good news for us because we have about \$2.8 million of programming that would have had to be eliminated.

Dr. Katz had promised to cover it in the general fund, at least through January, hoping we would have a resolution before that and it looks like we will. The details will be out in the next two days. So I just got a quick memo from the Governor's Office and from the Department of Mental Health that they are going to support the funding. Actually we may not get the full amount. We'll have to see what happens. Because they've decided that if they're going to add extra funding for the Mental Health Services Act, every county should get it, and only 42 counties actually have AB 2034 programs. So to spread it to every county gets us back into some kind of formula problems, but I will keep everyone posted."

Dr. Shukla: "And yet it's considered separate and not supplantation?"

Dr. Cabaj "Yes. It's still from the Proposition 63 funds."

Dr. Shukla: "Is that extra money from the Millionaire's tax?"

Dr. Cabaj: "It was an administrative fund; so it was separate money from what they had already doled out to us, but it still could get into supplantation language. People are working hard with their legal team to find a way to phrase it, that because the program's being eliminated, their clients might end up in a worst level of care. This money could be used to extend new services or continuing services to prevent worsening. They somehow think that's going to get around the supplantation language.

At this point nobody would challenge it because they'd be so happy to get the money. However, there's still talk of a lawsuit against the Governor for making the cut in the first place, and this is only a one-year fix. In fact, we'd have to face this again next year. And there's some interest potentially in asking San Francisco to take part in this lawsuit; so we'll

see, and that the lawsuit's based on the supplantation issue as well as the fact that the Governor defied the intent of Proposition 63, the Mental Health Services Act, which was to expand mental health services in the State, and that was a move that defied both aspects of it. So we may well look into that.

There was even a rumor that if there was a lawsuit we might also try to tag on and get the Children System of Care dollars that were cut just at the time the Mental Health Services Act was getting formulated. There was a vague question of whether that money really fit into the supplantation or not. But they may put that in, and it would benefit our county also because we had a nice big cut with the Children System of Care. So if the lawsuit proceeds, it'll take years and it may benefit us. But we won't know for a while. But at least we have a one-year fix, we think, for the most of our programs. We'll have to then see if the program continues and see what the funding is for next year, but again, there's been a lot of efficacy work, and I want to thank a lot of people who helped out with that. I know this is kind of confusing. We were hoping the budget would be all finished but it continues. Otherwise, the rest of the programs were fine in our budget.

Let me just walk through the other things since there's a lot of things to go over today. Our substance abuse prevention services strategic plan is moving forward. The reason we singled out substance abuse from all the behavioral health services is because there's a state requirement to provide one. We still are looking at integrated behavioral health services, but we had to satisfy the state's requirement. We worked in conjunction with Ginger Smiley and others, people in the Department of Health, around prevention efforts. And it's a very nice plan that will be coming forth. We think it will really help address some of the major needs. It's heavily focused on youth. And when the Mental Health Services Act prevention dollars ever get released or the mandate on how to use them comes from the State, we then will make sure that this plan dovetails with those planning efforts.

As I mentioned, the budget was okay. Just one added item. I think people may have been told that Walden House was going to close its adolescence program, which was treating adolescent boys and girls at two separate facilities. Well in fact they did close but then reopened with some monies that we were able to find primarily through the Board of Supervisors' additions.

They recreated a program that's only for San Francisco residents. Their other program was opened to children throughout the state. And at this point they reopened the boys' program not too far from here on Haight St., near Laguna, and the girls' program is out near City College. As of yesterday, there were nine boys in the program. Eventually there'll be 20. And there were four girls eventually growing to ten. The program will be operating as a 30-bed unit, focused heavily on behavioral health needs. The main referral source will be children from Juvenile Hall. It's an attempt to make sure children can get out of the Hall quickly and into a treatment facility. And it's specifically oriented to help with family reunification; so they're going to try to tie families in as much as possible to avoid foster care and see if they can break the juvenile delinquency cycle early so there won't be future periods of jail time for these youths. So far, there's been good success even with the few weeks that the program has been opened."

Dr. Moses: "What age group?"

Dr. Cabaj: "I think it's 15 to 18, although they can take a little bit younger range, and they do keep it separate for boys and girls. There's school training at the site so the children don't have to get transported somewhere else."

Dr. Turner: "And who's been behind this family push, because that's a really important piece?"

Dr. Cabaj: "We were. It was a nice time to do this because we certainly didn't want to lose the program. The nice thing about Walden closing is we could redesign it, and we worked closely with them and they're very satisfied. In fact they're using evidence-based programs. We can get you more information for the next go-around. They put out a nice description of the program and it's one of the first ones, so to speak, that's run solely on evidence-based practices."

Dr. Moses: "I think the reason why I asked for the age group, is because I know the City turns the youths out of the programs at 18. So what happens to a program like this?"

Dr. Cabaj: "Well same thing. They can age out. I believe they can stay until 18. They haven't had anybody in there up until the age of 18 yet because the program just started, but once they reached that age, they would then go to the adult system and we would have to come up with the right placement. But they're very excited about a program that isn't time limited. Their aim is that it'll be a 90-day program, but they don't put that limit on any child because they've learned in the past if a child thinks they've got 90 days, they don't do anything positive for the first 85 days; then they behave well for the last five days and then they're out. And since the youths don't know when they might actually leave, they seem to get much more engaged, and so far they've shown that children are moving up their privilege levels. So there seems to be real engagement and wanting to get better at the system level. So we're hoping it will continue that way."

Dr. Moses: "These are brand new programs, right?"

Dr. Cabaj: "Right."

Dr. Moses: "Are there going to be any facilities in the southeast sector of the City?"

Dr. Cabaj: "They're using the facilities they already have. There's no way to get a brand new facility. We could have lost them for any use whatsoever, so we were very thankful that they could be used. And the girls' center is right on the edge of Visitacion Valley down in the Ocean Avenue area."

Dr. Moses: "Well I just want to reemphasize the importance of this matter. Please don't forget the Bayview."

Dr. Cabaj: "I understand. And I know you wanted some information from my last presentation, and we can talk about that too. It's never far from our minds but again, it's the idea of finding the funds and resources. I'll insert one thing now. We're looking at new ways of funding housing and if the State allows some flexibility, we might be able to do smaller housing units, which would open up some possibilities in the BayView and Hunters Point area that we didn't have before. We wouldn't have to look for very big buildings or very big housing units, which would be difficult to find. I've been talking to Mark Trotts, who runs our housing programs for the Department of Health, and we're

very excited that, if there's a change in the way we can use the money, we can start looking at areas that we couldn't normally use because of the size and cost before.

So let me just move on with the report. A lot of this is more information because we combined two months' worth of material here. We had a new review of the program objectives for working with our Civil Service workers and contractors and we believe we've had good input. I think we've got some contractors here who may have some thoughts, but we believe we're coming up with objectives that are actually useful to measuring the progress of clients as well as the delivery of services.

We've expanded our system to respond to gun violence. That was the original name for the program, but it's really all violence. It's been a program that's been operating for about a year or two through the Children's Crisis program. We're adding a heavier adult component because most of the victims of violence and the family members that are affected are between 18 and 30. We have gotten volunteers throughout the entire CBHS system to help out because we need a lot of evening coverage, and we'll be turning to more and more contractors for help and Walden House has already stepped forward with four volunteers and it's responding to the actual site of a shooting or killing. Response is based on the number of actual deaths.

We sometimes get involved with severe violence situations, but it's often usually a death, and there's a whole tiered system that comes in. So we're hoping it would both help the situation for the families and other people that may be involved and in the long run help prevent post-traumatic stress and other reactions that occur from these situations. So we'll be doing another wave of requests for volunteers because we hope to have 15 consistent volunteers that can rotate, and I've been able to get some additional staffing for it through the Mental Health Services Act; so we'll have a core team of eight people working regularly. We're real excited. It started out with three volunteers so we've really been expanding."

Dr. Turner: "Just to insert one thing. When you make a comment say your name unless I call your name first for our transcriptionist. So far we've had Dr. Shukla and Dr. Moses."

Dr. Cabaj: "We're continuing our integration efforts and many of you have sat in on some of the meetings. We are still working with Ziallogic, and they'll be here at the end of the month, September 27th and 28th so we're excited about that. The plans are moving ahead around trying to find a consistent way of doing better billings so we can capture all services, whether it's a primary substance abuse, primary mental health, or combined service, and we still have our active change agents who are leading the forefront.

There's also an update on the Mental Health Services Act. As you know, we're starting to keep that in as a regular monthly update so it will describe – I won't go over in detail because it's right in front of you there – the numbers of adult, older adult, transitional youth, and youth that have been served in the Full Service Partnerships as well as the continuing expansion of outreach and engagement through our programs that are not specific one-on-one client programs but are peer drop-in and other programs."

Dr. Shukla: "I think it's great that the numbers enrolled exceed those expected. My question is about ultimately the goal of improving health outcomes. And so in addition to

the enrollments, do you have any numbers or any measurements on how well these strategies are working? It's great that these folks are getting enrolled, but are they getting better?"

Dr. Cabaj: "We hope. It's a little too early yet because the programs are not even quite a year old. In terms of engagement and enrollment, every client is tracked through this thing called CSI, which is Client Services Indicators. It's a state devised evaluation tool where you log in the information when you first work with somebody and any time there's a critical incident like being hospitalized or if they end up in jail, it has a required update. So we will know exactly how people are doing once we get this information, and that data goes to the State. We will have the information first, and we'll work with it to improve client services. We'll combine that data with a thing called Caloms, which I've talked about here before. It's a new evaluation tracking system for the substance abuse side of the programs and they're very similar but there's not total overlap, of course. We should have some outcomes data within a few months. It usually takes a half year to collect something that's significant and takes a half year to analyze it, so we should have something soon for you."

Dr. Shukla: "Great. My second question was is there any work being done on improving communication between all of these services?"

Dr. Cabaj: "What do you mean?"

Dr. Shukla: "Sharing of information. It seems like there are these peer-based wellness centers, supportive services, vocational and rehabilitation services, violence, traumas. Is information shared between all of the various groups? I know initially there was a lot of discussion about improved communications, improved IT systems between the medical centers, the outpatient services, and the housing services. Has there been any work done in the last year on that?"

Dr. Cabaj: "There's a regular weekly meeting of all the evaluators and program managers of each of those programs, and they all get together in a room with our coordinator, Deputy Director Alice Gleghorn, whom you've met, and Maria Iyog-O'Malley, who's coordinating the Mental Health Services Act work. I think it's once a month, that all the programs get together themselves to share what's going on. And I think I mentioned here previously, that we created an every other month Oversight Committee for the Mental Health Services Act.

The biggest communication gap is still electronic. We're working on that. As you know, our own system is primitive, to say the least. We're getting a new system within five years. I know that sounds forever but it's not very long in the scope of things. We'll have a brand new system. We've been starting to use a thing called Clinicians Gateway, which is an electronic clinical record tool that includes the CSI and other evaluation tools. So they have a little more electronic communication. I don't know if it's in any other part of our system, but it will get better within the next few months or half year to year. I hope that helps somewhat address the communication issues.

I think the rest of my report is looking at some of the things coming up. In regard to our Workforce Training program, the State has given us some clear guidelines but we still have

to submit a plan. Most likely the money for education and training and workforce development won't be available until January. In terms of the Prevention and Early Intervention component of the Mental Health Services Act, the guidelines are not entirely clear.

In regard to our housing efforts, the State has given out such little money to the counties, and they've made the application process so complicated that many counties are not even going to bother. But we will see what we can do to make sure we maximize whatever we get and that could also help support some of the housing I mentioned earlier that could be used in the BayView and other areas. The information and technology efforts are still very far down the road and innovations are so far off the screen they don't even talk about it.

One nice thing is the Oversight and Accountability Commission, if people remember, that's a Governor appointed body that reviews the Mental Health Services Act and has the specific power to approve prevention, early intervention, and innovation dollars. Dr. David Patting, I don't know if people know him, he's an 'addictionologist' and physician at Kaiser, has been appointed to this commission, and he's been very engaged. He's come to our Oversight Committees and he wants to meet regularly. So we feel we've got a very nice San Francisco voice in this area which we hope will help.

And then there's a lot of training events coming up, but I'll leave that up to you to read and review. We're excited about the ongoing training efforts that we do for our county.

The Full Service Partnerships with the Children, Youth and Families Division of Family Mosaic Project are working in collaboration with Seneca in doing an intensive wraparound to have children and families stay in the community and work. This is based at Family Mosaic, which is in the BayView, but no BayView based program applied for the Mental Health Services Act dollars in the Request For Proposal (RFP). So again, you can't award services except to people who apply to the RFP.

There was also a request at the last meeting to show where people who are treated in the Full Service Partnerships live. We have 192 clients and we looked at where they said their zip code of origin was or if they were homeless. This would give you information on our Full Service Partnerships so maybe you can make a copy of that and we'll distribute that later. What I handed out is a list of all the programs just by zip codes that are in the southeast sector of the city, so they include everything, no matter what the funding is.

The first table was done by the Child, Youth, and Families program. The second set of information is all of our programs. As you can see, there's a good number of mental health subsidies and dual programs throughout, but very little or no residential programs except Jelani House, and that again has been partly a question of geography and partly of affordable housing. Many people targeted what was perceived as the homeless areas first for housing like the Tenderloin and the Mission and South of Market. And as we certainly have learned with the Homeless Outreach Team and others, there's a huge homeless population in the BayView in the parking lots and under the highways there. So we hope to extend the study of this issue, but this again is dependent on future funding. But this list is relatively comprehensive as of this afternoon."

Dr. Moses: "I know you mentioned the Jelani House, and of course Jelani House is just for women, right?"

Dr. Cabaj: "And children."

Dr. Moses: "And children. But our concern is there are no residential programs in this part of the City."

Dr. Cabaj: "I hear you,"

Dr. Moses: "And I know you keep telling us you're going to do something about it. You know, we just want some action. It's unfortunate that not too many programs apply for the funding. I wish there is something that could be done about that. I know you can't force people to go into a program, just like you can't force anyone to drink water."

Dr. Cabaj: "Exactly."

Dr. Moses: "But, you know, something needs to be done."

Dr. Cabaj: "Sure. Any new monies we get will be used to address this issue. We hope and we encourage people to apply. I can't go to a particular program and tell them to apply because it will look like favoritism. But we offer training on how to fill out RFPs. We want to encourage even a smaller organization that may not have felt they had the wherewithal to do it to help them apply. So we'll keep looking at it as the months go on."

Mr. McGhee: "When you say it looks like favoritism, it seems to me that community outreach allows you to help organizations with the process. It's not favoritism. And I always have a problem when someone says that 'well it looks like favoritism. We know that there are some organizations that are not as sophisticated as others. We talk about taxpayer dollars, and people in the BayView pay taxpayer dollars like everybody else. So I think when you're talking about educating any community and community outreach, for example, a proposal just came out from the San Francisco Public Utility Communication (PUC) on community outreach. So why can't you do, for example, a workshop in the BayView Hunter's Point area on community outreach? Does this contract state about not working with small micro businesses and community outreach so they're aware of the process of the PUC? To me, and I'm not just talking about the BayView, in general, community outreach means every area in San Francisco. So, if you see an area that's not participating, then you have to say there's a reason why and it's up to me as an employee of the City to investigate why you aren't participating when it has such an impact on your community."

Dr. Cabaj: "I know what you're saying makes sense. I just am saying what the legal counsel's told me. What I do is make sure that when notices go out, every program that we're aware of receives them, and I ask people to think of programs that aren't necessarily listed, and find a way to get to them. And the mailing has to come from the Office of Contracts because if it looked like I was doing it, it might be perceived as favoritism. I'm supposed to be the ultimate decider of the RFPs so that's one of the reasons I can't say much. The idea of a workshop is great. We did that with the Mental Health Services Act and it did help people learn how to work with RFPs. We've done trainings for peers and others who've never been on an RFP review panel; so they can also help with selections.

We've been trying to make sure we get the broadest base of people that can help in the selection process."

Ms. Brooke: "Is it possible that the Mental Health Board be notified when the RFPs come out? I get a few here and there if somebody sends me one, but I'm not on the regular list. And then maybe as a board we can be part of that process to let more organizations know."

Dr. Cabaj: "Sure. That's a good idea. Just call Jackie Hale, and ask to be placed on the mailing list."

Mr. McGhee: "Maybe we can do a workshop."

Dr. Cabaj: "Sure."

Mr. McGhee: "And then invite a city partner to come out and talk about how to get more involved."

Dr. Cabaj: "That's great."

Mr. McGhee: "And if you can't do it, then we can definitely do it."

Dr. Cabaj: "Well we can help with a workshop. I just can't call the individual programs to apply."

Mr. McGhee: "Sure, we understand. But I'm just saying try to come up with the mechanism that will allow you to get more information out to the community."

Dr. Cabaj: "Absolutely."

Mr. McGhee: "They need that information. And if you can't do it then the board can talk about it."

Dr. Turner: "Board members also can call places."

Ms. Brooke: "If they come to me, then I can let people know."

Dr. Turner: "Maybe we can come to a workshop."

Dr. Cabaj: "It's a good time. Because of the interpretation of how long a contract is allowed because of county counsel, we'll probably end up doing a lot of RFPs soon for every service again. So that would be important if you came."

Ms. Kellum King: "Thank you for this information, Dr. Cabaj. I have a concern because I live in Visitation Valley, and if anybody's looked through what you handed out, there are only two programs in the 94134 area, where 94124 is full of programs. And we still have that turf issue. I think that it should be brought to the attention of CBHS that more programs are needed in the immediate Visitation Valley area."

Dr. Cabaj: "I included that map, which I don't know if it's exactly up to date, but again, it is glaring how some areas obviously are lacking in services."

Ms. Kellum King: "It's true in many ways."

Dr. Moses: "One question in regard to Item 6 in your report. I remember when Zialogic came here years ago, and I was around when their contract was awarded. Since we are talking about cost effectiveness, how does their contract stand?"

Dr. Cabaj: "We review every contract regularly. What we've actually done is cut their contract year after year because we've decided they've helped us so much in the beginning but now a lot of it comes to us. So they more or less give guidance and check in periodically. They used to come monthly, now they come quarterly. So we've reduced the contract dramatically in the last few years, and I said to our coordinator of the programs, Dr. Gleghorn, that this may be their last year. At this point we should absorb the ability. But we think they have been cost effective, both not only in shaping programs, but giving us guidance on the billing and other revenue issues. So we believe we've been able to capture revenue in areas where we might not have done so without their help. So if we just look at it from concrete dollars that way, there's been some help. But in terms of getting a program design, it's hard when you're working in your own box, so they helped us look outside of the box, I think."

Dr. Moses: "I just think it might be a good idea to see if we can find some money to provide real residential services to the BayView. They need it."

Dr. Cabaj: "We are going to have another big meeting soon."

Dr. Moses: "The fact that there are no FSPs in Bayview/Hunter's Point, a very important part of the city, is concerning."

Mr. Hines: "I was going to piggyback off what Mr. McGhee was saying about us reaching out to these people. What if we formed a committee specifically for that, to reach out to communities that we are not getting a hold of, and that are not applying for these options and these RFPs. What if we had a committee of three or four people on this board that, once a month went out to different areas and I don't know how plausible this is, but went out to different areas and talked to these people about applying?"

Ms. Kellum King: "On last Friday night, just before the 11 o'clock news went on, there was a flash that there was a post-traumatic stress disorder (PTSD) conference in Visitation Valley the next day, which would have been Saturday. Well I looked all over Visitation Valley where I thought it might be, and I wondered did you have any knowledge of any such conference?"

Dr. Cabaj: "No, I wasn't aware of that one."

Ms. Kellum King: "It was going to take place on Saturday. So I went to the community centers, because if something is taking place in my community surely I'd like to know about it, and neighbors would like to know. There was just that flash in the news, and I called someone and they said they had gotten an email the day before. They knew a Dr. Mills was putting it on but they didn't have a clue where."

Dr. Cabaj: "Sorry, I didn't know it. There's a lot of focus on PTSD now, as you see."

Ms. Kellum King: "Right, but serve the people who need it and who can use it."

Dr. Cabaj: "Right."

Mr. Purvis: "It'd be very hard to go out just cold to talk to individuals. So do we know what's out there? I mean, a list of programs or even beginning programs?"

Dr. Cabaj: "The City keeps a list of all contractors or anyone who's potentially interested in providing a service to the City. We do not know about anyone who's starting up and hasn't had formal contact. If anybody calls me to say, I'd love to help provide services and they've not been a prior contractor, I immediately hook them up with the Contracts Office because they have to do a whole lot of pre-work. We will do what we can to help shepherd a new program. We can help teach them how to become Medi-Cal eligible; how to make sure they have their staffing patterns right, and other procedures and tactics. So we do a lot of work with new organizations. For example, we're trying to work with the Lighthouse for the Blind. They've been very interested in becoming a mental health clinic. They've noticed that many of their older adults with vision impairments are very depressed and they've been afraid to go somewhere else for care because it's hard to maneuver. So I would love to bring the care to them. It's right around the corner. So we're looking at a brand new way to shepherd them through a process of learning how to be a mental health program. But then they'd have to apply for an RFP for services when that comes out."

Dr. Moses: "On the positive side, I just want to thank you for compiling this information, and going out of your way to put it together for us."

Dr. Cabaj: "Thank you."

Dr. Turner: "Thank you Dr. Cabaj."

Monthly Director's Report **July 11, 2007**

1. **AB 2034.** As is well known, the State Budget was passed quite late this year and included continued funding for AB 2034, a program that serves over 120 mentally ill, homeless clients in San Francisco with a budget of \$2.8 million. The Governor "blue penciled" the program—that is, he specifically cut AB 2034 as a line item deletion—even though days before he said he would keep it in the budget. The Governor says he recognized the importance of that program but there were other ways to fund it, including MHSA funds. However, legal opinion—even noted by the Governor's staff—is that MHSA cannot be used since that would constitute supplantation and that the cut itself may be illegal since it cuts funding that was in place at the time of the Prop 63 passage and breaks the laws intent of expanding mental health services. There has been tremendous outrage across the State in reaction to this cut. The California Mental Health Directors Association is working with the State Department of Mental Health to see if there can be some emergency bridge funding from unspent MHSA funds held at the State level—with language that would allow the funds to be used without it being seen as supplantation. There is also talk of a lawsuit against the Governor. In San Francisco, Dr. Katz, the Director of Public Health, has said that we can keep the program going on general funds dollars until the resolution is reached about other funding sources. We cannot take new clients into to the program or hire into any vacancies, however, until the funding is resolved. For now, there are 120 clients in the program and their services will continue as they have been before the cut.

2. **Substance Abuse Prevention Services Strategic Plan.** The City and County of San Francisco submitted a five-year Substance Abuse Prevention Services Strategic Plan to the State Department of Alcohol and Drug Programs. The Strategic Plan is a result of a two-year community planning process that involved youth, families, public agency partners and community-based providers. The plan provides a broad framework that will guide S.F. substance abuse prevention services. The plan is designed to be a living document that is responsive to new challenges that may arise in substance abuse prevention, such as the recent methamphetamine epidemic. There are four major focus areas under the plan based on an extensive community needs assessment conducted during the planning process. These include reducing youth access to alcohol and other drugs, changing norms and increasing public awareness of alcohol and other drugs, empowering community and promoting environmental change, and building system capacity. Substance abuse prevention providers will be asked to meet new objectives in Fiscal Year 2007-08, such as engaging young people twice per year to better understand youth attitudes toward alcohol and drugs and conducting an inventory of current practices to determine the most promising practices in preventing substance abuse.
3. **CBHS Budget News.** A new initiative was included in the Fiscal Year 2007-08 Budget. Walden House will provide residential treatment services to 30 juvenile justice involved youth (20 boys and 10 girls). Youth will be referred for services through the courts. The Walden House program was funded in addition to residential treatment offered through Edgewood Children's Center.
4. **07-08 CBHS Outcome Objectives.** I am pleased to announce that this year's CBHS Performance Objective Planning Committee led by CBHS CYF Director Sai-Ling Chan-Sew completed the final document of the CBHS Performance Objectives for FY07-08. Much appreciation is deserved by all who served on the Performance Objective Committee, for staying with the process and providing valuable input and guidance, as well as data collection and analysis, towards the development of the final document. Thank you also to Karen Strickland from Golden Bear, who facilitated and wrote the drafts of the document.

One of the important changes we will implement this FY 07-08 is to conduct a system-wide evaluation to collect client level outcomes using a random sampling method for all clients receiving service from CBHS. This evaluation will be conducted jointly by CBHS Evaluation and Quality Management staff for this new fiscal year, with input from providers. This system-wide evaluation recognizes that while it may be difficult to measure specific outcome by individual providers, we need to have information on the impact of our services, collectively as a service system, on the lives of our clients.

Another significant change we made this year is to separate quality improvement objectives, from compliance objectives, and from actual performance outcome

objectives. The result of this delineation is a more concise document (13 pages vs 25 pages for FY06-07).

Please let Sai-Ling know if you are interested in participating in our next planning effort for the system-wide evaluation. She can be reached at (415) 255-3439, or at sai-ling.chan-sew@sfdph.org

5. **Standby/On-call CBHS Staff Needed to Assist Families of Victims of Violence.** As you may well be aware, the needs of families impacted by violence continue to rise. Presently, we have a CBHS Violence Response Team that was created several years ago in collaboration with Community Programs and the Child Crisis Team. This Team, over the last two years, has responded to the needs of hundreds of families, including providing immediate crisis trauma support, as well as case management follow-up.

I am asking interested CBHS clinicians and other civil-service staff to volunteer to help us to respond to the needs of families impacted by violence. We especially need help during the most troubled times—evenings and weekends—and often in specific areas of the City—the Western Addition, Bayview, Hunter’s Point, Visitation Valley and the Mission. We would like volunteer standby responders to strengthen the Violence Response Team’s efforts, and I am seeking civil service staff who would be especially sensitive to the racial and ethnic issues for the communities at risk in these different parts of the City. Staff who have training in trauma-focused and crisis intervention training are especially encouraged to apply, though training will be provided to all of the volunteers.

Stand-by responder volunteers will be organized into a schedule that matches the needs of the community. Civil-service standby staff will receive on-call/stand-by pay and, if called in to help, receive compensation for the additional work as outlined in the particular MOU for the Union they are covered by. The on-call/stand-by will be for evenings and weekends (usually 7:00 pm to 7:00 am plus 7:00 am to 7:00 pm Saturdays, Sundays and holidays) and will be scheduled at intervals that will not disrupt the ability to work at regular job and duties.

I have asked Edwin Batongbacal, Director of CBHS Adult/Older Adult Services, to organize the volunteer efforts and he will work with Charles Morimoto, Deputy Director of Community Programs and supervisor of the Violence Response Team, and Sai-Ling Chan-Sew, Director of CBHS Children, Youth and Families Services and supervisor of the Child Crisis Team. Please contact Edwin’s assistant Antonio Trink at antonio.trink@sfdph.org to express your interest (please include the name of your immediate supervisor). **Thank you for considering volunteering to help the Violence Response Team.**

We are also piloting a collaboration with Walden House to have similar standby/on-call responders to provide immediate crisis support to families and loved ones of victims of violence.

6. **CBHS Integration.** Zialogic will conduct their Quarterly visit on September 27-28, 2007. They will present at the System Orientation Meeting and meet with the Change Agent Leadership group at the Ba'Hai Center on Thursday, September 27th. In the afternoon, Zialogic will meet with CBHS committees at 1380 Howard Street. Additional meetings with Integration committees are scheduled all day for Friday, September 28th at 1380 Howard Street. For more information, please contact Kathleen Minioza at 415-255-3585 or email at kathleen.minioza@sfdph.org
7. **Mental Health Services Act (MHSA) Update.**

COMMUNITY SERVICES AND SUPPORTS (CSS)

CBHS has conducted preliminary data analysis of the community services and support program funded by Mental Health Services Act (MHSA) in Fiscal Year '06-'07, and is pleased to announce that the total targeted enrollment rates were exceeded for the Full Service Partnerships (FSP) and Housing Service Partnership (HSP) programs. Eight FSPs were funded and all of these initiated services during the fiscal year. CBHS had proposed that 203 clients be enrolled across all the FSP programs during the initial year of services, 236 individuals were actually authorized during FY '06-'07. Two age groups (Adults and Older Adults) exceeded the targeted enrollment rates for the year (109 enrolled vs. 81 targeted, and 52 enrolled vs. 34 targeted for adults and older adults respectively). Through the Housing Service Partnerships, 32 clients received housing out of a targeted 30. General System Development funds were used to initiate 13 new programs to meet priority needs identified through an extensive community planning process. A grand total of 987 were served across a range of service programs including 736 at peer-based or wellness centers, 133 receiving supportive services to access of maintain housing, 32 participating in innovative Vocational Rehabilitation services, 28 in Violence/Trauma Recovery Services, 24 receiving culturally competent services targeting Gay, Lesbian, Bisexual, Transgender, Queer and Questioning (GLBTQQ) Asian youth, 16 enrolled in dual diagnosis residential treatment, 12 Transitional Age Youth (TAY) living in transitional residential housing, and 6 TAY receiving behavioral health services in primary care settings.

Congratulations to all the MHSA funded programs for their success in implementing these important new services!

WORKFORCE DEVELOPMENT, EDUCATION, AND TRAINING

The next meeting of the Workforce Development, Education, and Training Committee will be held on Thursday, September 20, 2007, from 12:30 pm to 3:00 pm, 4th Floor Conference Room, 1380 Howard Street. The Committee will convene to discuss final recommendations for the San Francisco Three Year Plan, to be submitted to the Executive Team for its approval and then to the State for its consideration and approval. If you have any additional recommendations or new comments, please e-mail them to Prop63@sfdph.org

PREVENTION AND EARLY INTERVENTION

We are in the early stages of recruiting members to be on the planning committee for the Prevention and Early Intervention component of the Mental Health Services Act. Some strategies and priority principles already identified include stigma reduction, recognition of early signs, and outcomes and effectiveness. Please consider joining us, as we begin forming the basis for our formal recommendations, to be submitted to the State later this year. To join, leave a message on the Prop. 63 phone line at 415-252-3084 or contact Kevin Ledbetter, MHSA Administrative Assistant, at (415) 255-3513.

HOUSING

Negotiations are currently underway with the Mayor's Office of Housing and the San Francisco Redevelopment Agency to come up with a viable projects and develop an RFP/RFQ for agencies interested in applying for the housing monies being released by the State this year. More information will be forthcoming as this process moves forward.

INFORMATION TECHNOLOGY

We are now soliciting for recruitment of consumer participants for the Planning Committee, to be initiated sometime this fall. To join, leave a message on the Prop. 63 phone line at 415-252-3084 or contact Deborah Vincent-James, Information Technology Manager, at (415) 255-3635

MHSA ADVISORY COMMITTEE MEETINGS

The Mental Health Services Act Advisory Committee meets bi-monthly from 3-5pm, alternating between advisory meetings and community forums. The date and location of the December community forum has yet to be decided, and will be announced at the October Advisory Committee meeting. The next scheduled meeting is as follows:

Thursday, October 25, 2007
Advisory Committee Meeting
1380 Howard Street, 4th floor conference room

8. Other Upcoming Events:

PERINATAL SUBSTANCE ABUSE: Motivating Patients (and Providers) for Change –
Friday, September 21, 2007, 8:30 am – 1:00 pm @ Hiram W. Johnson State Building
Conference Center, Ken Saffier, MD, Addiction Medicine Specialist.

ANNUAL CBHS SYSTEM ORIENTATION - Thursday, September 27, 2007, 8:30 am - 12:30 pm @ Ba'Hai Center , 170 Valencia Street. This annual training is designed to provide CBHS, DPH and other county department personnel, both clinical and administrative, with an overview of CBHS mental health and substance abuse services. This is an excellent orientation for newer staff and interns. Come learn about what services are available, how to access them, consumer involvement and an introduction to administrative requirements. To register for this event, fax your name, organizational affiliation, e-mail and/or fax number to (415) 252-3057. Or for more info, call (415) 255-3553.

A FORUM ON THE RECOVERY MODEL AT WORK IN CBHS - Friday, September 28, 9:00 am - 12:15 pm @ Ba'Hai Center , 170 Valencia Street. Keynote Speaker is Bob Cabaj, MD, CBHS Director. Moderator: Jennifer Baity Carlin, LCSW, of San Francisco Behavioral Health Center. Celebration of Recovery Month to follow at Glide Memorial, 330 Ellis St., @ 2:00 pm

THE IMPACT OF SUBSTANCE USE ON THE BRAIN AND BODY – by Jennifer Baity Carlin, LCSW, October 5th, 9:00am – 5pm @ Ba'Hai Center , 170 Valencia Street

To register for these trainings, please contact Norman Aleman, CBHS Training Coordinator at 415-255-3553 or email norman.aleman@sfdph.org

Past issues of the CBHS Monthly Director's Report are available at: <http://www.dph.sf.ca.us/CBHS/default.htm> To receive this Monthly Report via e-mail, please e-mail kathleen.minioza@sfdph.org.

1.1 Public comment relevant to Item 1.0

There was no public comment.

Item 2.0 URGENT CARE CENTER

2.1 Presentation: Urgent Care Center, Liz Gray, Director of Placement, CBHS, Steve Fields, Executive Director, Progress Foundation, Dr. John Nikens, Director of Clinical Services, Progress Foundation, Erin Williams, Deputy Director of Clinical Services, Progress Foundation.

Dr. Turner: "It's great to have Steve Fields here. Steve Fields is Executive Director of the Progress Foundation. I was hoping Dr. Katz would talk with us as well so that he might be able to answer our questions, since he developed the Urgent Care Center. Unfortunately Liz Gray was not able to be here this evening because she is honoring Roshashana."

Mr. Fields: "Hello, good evening. It's nice to see many of you again. Some are new. With me is Dr. John Nikens, the Director of Clinical Services at Progress Foundation. He's been in that role with me for 25 years, and Erin Williams, who's a Deputy Director of Clinical Services, who has been in charge of our Acute Diversion Programs, where we have provided one level of care in San Francisco since 1978. Our Diversion Evaluation Team goes into San Francisco General Hospital's (SFGH) Psychiatric Emergency Services (PES) component and the hospital to work with staff there on diverting and getting people out. Ms. Williams will be the deputy in charge of the Urgent Care program. She and Dr. Nickens are here also to answer questions.

What I'll do is give a brief overview because I think probably the most important thing would be then to get to the questions that you have that aren't answered by my presentation. I have a write-up here that describes the Urgent Care process. I'll pass it out after I'm done.

Progress Foundation, for those of you who don't know us, has been a contract provider in San Francisco since 1972. We started in 1969 before we developed our first contract. The agency's focus of service is to offer alternatives to institutional treatment. We started with what would be conceived as the old classic halfway house back in 1969. Since that time, our services cover Acute Diversion Units, which, those of you who are familiar enough with the system are represented by La Posada, Portland House, Schrader House and Avenues, which take all of their referrals directly from the PES at San Francisco General as a diversion from inpatient or cleared.

There are 40 beds total in that system of services. The most recently opened program, Avenues opened in 2000-2001. The second level of care is transitional residential treatment. We have La Amistad and Progress House that have been around a long time. And we have a seniors' residential program, and Carroll House that serve people in a social model. These are all recovery-based or rehabilitation-based interventions — for people 55 and over. We have Ashbury House, which is the first program in the country for mothers diagnosed with a severe mental illness; so the children live with the moms while they go through up to one

year of treatment. And we have Clay Street, which is a program that serves people coming from the Institutions for Mental Disease (IMDs) or being diverted from going into the IMDs. That's a one-year transitional program with that particular focus. Then we also have an array of what we call satellite apartments or co-op apartments, which are shared living. It's supported housing before the term was discovered by mental health, at least five years ago or whatever. We've been doing co-op apartments since 1969, which is shared apartments by three or four clients. We provide 24-hour-a-day, 7-day-a-week case management support to the residents in those apartments. I think now we have something like 17 apartments.

The third thing we've done since 1990 is build permanent supportive housing through the United States' Housing and Urban Development Office (HUD). We have four buildings in the city that we have built that are affordable housing for the maximum stabilized level of service. Again, we offer case management to residents there if they want it. If they don't want it, it's not a condition of being in the HUD housing.

So that's the array. I think outside of looking at underserved populations such as women with children and seniors, most of our emphasis as an organization since we developed the first Acute Diversion Program, La Posada, has been looking at where people are at risk of being institutionalized and trying to develop a community-based service that whenever possible diverts people from or gets them out faster from institutional settings. We believe community-based services when they're done right are the best places to serve people; and the resources of inpatient services, particularly. They are valuable resources that are not growing financially and in other ways, and we need to use them in the most efficient, targeted way possible so whenever a community alternative can be developed, that they can take the pressure off. This makes sense.

I think we developed the first Acute Diversion Program (ADU) in the country at the level that we have, working with people referred by Psychiatric Emergency Services (PES). And when we first proposed it, nobody thought it was a good idea except me and a few people who were crazy enough to go along with me. I think the Mental Health Board in those days actually voted against it because it was too risky a thing to do. I didn't have a lot of support, but we did it and the ADUs now are a central and important part of our community treatment system because they've proven that the premise behind them, and I would add because of the support of Dr. Nickens and others, the competency of our organization proves that when we're proposing a program we generally aren't out in left field making things up out of nowhere.

To cut to the chase, for at least eight years I've been proposing to different mental health directors and to different health directors and to different health commissions the idea that we should look at doing a community-based emergency capability to take the pressure off Psychiatric Emergency Services (PES), that that service should have logistics working in its favor. Meaning that it should be connected to an alternative, an ADU, right in the same building just like PES is connected by an elevator ride to the inpatient units; so that if we want to divert, we should have the opportunity for the assessment and triage to occur whenever possible in the setting that you'd like to be able to refer people to if you can possibly avoid hospitalization.

It hasn't necessarily been an idea that has caught fire for a lot of reasons that I've become familiar with throughout my entire career. I've spent a lot of time in the public mental health system, a lot of time analyzing what we do wrong and what we could do better and a lot of time developing programs that actually put our money, I guess you'd say, where our mouth is and trying to do things that actually change systems.

There are a couple of circumstances that we could spend a day's seminar on that have made it important to look at the proposed ADU model again. First one is that for at least a year and longer, somewhere around 60% of the people on psychiatric acute units do not qualify for the full acute rate. They've been on what's called administrative days. I don't have time to explain that all to you in this meeting, but it's a lower rate than the full acute rate for Medi-Cal. So we have our most expensive, important service for the people who need it, whereas as much as 60 %, and that's a low estimate on some days, of the people in those beds are not by Medi-Cal review. There's no fault in this except I would add there's a systemic fault. We could have been addressing that and we should've been. It is not right to have people in an involuntary setting who don't need to be there, whether it's one or it's 30. 60% of 82 beds is almost 50 beds. So we have that problem. We have the backup that contributes to that problem, waiting for IMD beds. You have the question of whether or not there needed to be an admission in the first place, depending on how tight we are at the PES level about diverting whenever we can."

Ms. Brooke: "Could you not use acronyms? Not everybody understands them?"

Mr. Fields: "Oh, I'm sorry. Do you want me to use the full word every time? PES is Psychiatric Emergency Services and ADU is Acute Diversion Unit. IMD is an Institution for Mental Disease, which is the billing terminology for skilled nursing sets, mainly out of county, but we have one here that's now called the MERC, the Rehabilitation Center.

So that reality plus the pressure hitting PES, the Psychiatric Emergency Services, that creates the red alert situation, the backup in that center, then the frustration of the police and an ongoing story that waves through us on a regular basis is a problem. I believe that we can develop a community-based psychiatric service that could shortstop people who are on their way to PES, get a full triage assessment capability done, not at PES in the hospital but in the center, a voluntary setting, with beds there to refer someone into an Acute Diversion bed right there in the same building; so that we have a 24-hour capability. If we keep doing the same thing we're doing over and over, we're going to keep getting the same results, which is beds backed up in the hospital because we still haven't moved people out fast enough who don't need to be there, thus not having beds available for people who, when they get to PES, are acute and relying forever on a relatively un-expandable, high cost service that if we just kept opening inpatient beds it will eat up, disproportionately our mental health budget over time. I think, because we've had a great partnership with the hospital since we opened La Posada, and I think an even better one in the last eight or ten years, that the hospital agrees with the idea that we're not going to double the unit. We're not going to add beds to hospitals, we're going to have an increasing complex set of issues hitting us as a system, with a need to make sure those 82 beds are used in the most efficient way. And no matter what else we say that we've all participated in, they're not used that way now when 60% of the clients are not even

qualifying. One way to do something about it is to try and divert that emergency admission in the first place.

So I put a proposal together again. I already had one but I updated it, and met with Barbara Garcia, Liz Gray and Dr. Katz to present the idea of doing this; saying now is the time. I would have thought it would have been a great Proposition 63 program, but there was only \$80,000 in the whole allocation for residential treatment. So even if someone in the BayView or other community wanted to apply, that's not enough to open a treatment program. Residential treatment actually got the least amount allocated to it.

So I presented it and it got rolling. The choice then that Dr. Katz made – and I'm not saying this because I am distancing myself from it, but it was not my proposal – to fund this new program through closing 14 acute inpatient beds and shifting the resources from that to this program was his call in consultation with Community Behavioral Health Services (CBHS). I will say I agree with it, but I didn't propose it. I agree with it because I think it's a sound and conservative step to take.

There are a couple of things about the program that have been misunderstood that I want to clarify, and I take responsibility for them. A). I apologize for not coming to you sooner and talking to you about it. B). There's a lot of misinformation out there that I probably could have helped clarify. I want to make sure if we disagree, we disagree over the right thing. There is not a unit being closed at San Francisco General Hospital. There are 14 beds being reduced. A unit is 22 beds. There's no decision made to close the Asian Focus Unit or the African-American Unit. In fact, Gene O'Connell, the Executive Director of the hospital has said as much to me. That's not what they're doing. There are 14 beds being reduced out of 82 in order to shift the resources to this project. Those beds will not be reduced until this program opens. So if it takes us until June to open, the beds aren't reduced until then. And there's been a lot of misinformation, for whatever reason, out there about how precipitous this is or this isn't. The closing of the beds is meant to be segued into this program.

The program is designed now as a 16-hour urgent care program. The drop-in triage PES piece is between 6:00 a. m and 11:00 p.m. And the reason for that is both caution and finance. When we looked at designing the program and I met with Dr. Katz about designing the program, we looked at our own curve of frequency of people brought into PES, and by far the lowest time that people are brought into PES is after midnight up to 6 a.m. The peak is during the day. So there's a cost efficiency issue of staffing an alternative PES sitting there from midnight to 6:00 a. m., and getting maybe three, four or five people brought in. So we're opening smaller, and if it proves that it works and we need to expand it, it's easier to add hours than to go the other way and open it 24 hours and have people drain the resources and have people sitting around. So it's a 16-hour urgent care program with a 24-hour acute diversion residential treatment program attached to it. We've been doing a lot of talking to Mobile Crisis, to PES, to Westside Crisis, and we identified at least two, we hope three, of the community-based programs that have the highest number of people who are brought in on 5150s so that we can put our program in the pathway reliably of the highest utilizers of the 5150s, the premise being a community clinic knows somebody is heating up and getting more and more agitated.

You cannot call the police when they're just being agitated. You have to wait until they can be 5150'd and brought into PES or the police will just go away. You can't do a 5150 until you have the basis for it. But at this stage, we are able to identify people who are close to being 5150'd. In another day they will be acute enough to be brought in. We're proposing that that person come to urgent care earlier, or first, as an example. Mobile Crisis feels another place to bring people where they can leave and go, where the assessment will be done and where they don't have to worry about a bed or an admission, will work for them too, and they've been very supportive of this project.

There are a lot of questions to answer. There were a lot of questions when I proposed La Posada in 1978. If I'd waited to answer every question before I got excited about a programmatic idea we wouldn't open anything new in the City. Everything Progress Foundation has done, frankly, I was told by the powers that be, you can't do that, that won't work, and I just don't listen to that anymore, I just try to solve the problems that need to be solved. There are a lot of questions to answer. But we're in September and the budget is based on opening at the earliest mid-January. We're not going to make that date because of the site search is taking longer than I'd hoped. So we have time to work with the police and the other system elements, to get the ADUs in place, to work with our major partner, which is going to be PES, around the threshold between us and them, and then to produce 14 acute diversion beds to mitigate the loss of 14 acute inpatient beds. But remember, probably those 14 acute diversion beds are going to be people more acute, certainly more in crisis, than at least the 14 that are waiting on the inpatient unit.

So I would argue we're presenting an exchange of beds that's at least at a higher acute triage contribution to the committee than people sitting on the unit waiting for an opening at a skilled nursing setting. That's what we're planning. There's no bad guy – well maybe us, depending on how you feel about it – there's no bad guy. We're trying to improve a system that's going to break even more if we don't try something different. And our experience tells me that this will happen if things don't change. If we can divert just 30% of the police calls going to us or being avoided altogether and instead of to the psych emergency, we will help the police out. There are enough people who should be 5150'd waiting, who are at that level who aren't 5150'd because we don't have another service to offer. They're waiting to turn into 5150s and we're proposing to target as much of these people as possible where they are and divert them quickly. So if we can cut 30% of the police workload, they're going to get to do police work. They're going to not be pressured to be a taxi service for psychiatric services and that's the working premise in our getting a probably complicated process, a cooperative arrangement with the police. So I'll stop there with that part and take questions."

Ms. Brown: "Will this new ADU be able to seclude and restrain patients?"

Mr. Fields: "No. Like none of the existing ones do, it will not do that."

Ms. Brown: "And since this is voluntary, do they have to take the medication that's being offered or do they have a choice?"

Mr. Fields: "They have a choice but they can refuse medications in involuntary treatment too. But they have a choice in our program."

Ms. Kellum King: "Let's say my daughter has been ill for a few days, the agitation has grown and she's escalated and I bring her into that facility. Can you describe the level of care that would be provided for her and who will staff it?"

Mr. Fields: "Dr. Nickens can answer that question."

Dr. Nickens: "The Urgent Care Center is staffed primarily by licensed medical professionals, psychiatrists, nurse practitioners, and licensed mental health workers, with the support of lay counselors to help do some case management. What happens is an immediate assessment and then a triage to determine what would be the best course for the person. But that's what the Urgent Care Center was for, rapid assessments, triage, onsite treatment and referral out, if that's appropriate, and referral into the crisis residential program, if that's appropriate.

Important early in the process, is both developing our own services that we have access to right now, the existing 40 days plus the new beds that we would have, and also in the process of developing MOUs and understandings with other providers at different levels—the residential treatment level, hotel levels, supported hotel levels, and shelter levels—and then also working closely with PES. So our intention is not to put people out on the street. Some people might go back home. It depends a lot on the assessment that was done and the person's capacity to self-manage in the setting where he's taken to."

Ms. Kellum King: "When you say go home, like to the room they were living in or back to their parents' home?"

Dr. Nickens: "Both."

Mr. Fields: "Both, depending on what they wanted. They would need to want to go there and then the receiving home would want to receive them. But it would be their choice based on where they were."

Ms. Kellum King: "So if the family says no to the patient coming back to their home, what happens then?"

Mr. Fields: "Then we have a dilemma to solve, which we will. We don't put people out on the street with that dilemma. One of the things about the new ADU beds is that they're two weeks length of stay, maximum. They're a rapid turnaround. Average stay has always been somewhere between 12 and 16 days, depending on circumstances in the system. Our working premise with the new 14 beds is it's as short as a one to five-day turnaround so that we keep beds open just for that one set of circumstances."

Dr. Shukla: "I want to applaud your energy and your commitment to this field from everything you've described with this program and all the other connected programs. I think they are really impressive. And I really appreciate this idea of a community-based emergency resource for these patients. I think it's a great idea. Where I'm a little bit confused is the connection of your program that is starting, and the closing down of the inpatient locked rooms, and how those two have come together. In a way to me, they seem like apples and oranges. I kind of understand your logic in that there may be patients that are kept longer than needed; and so the idea is that by decreasing the number of beds there will be efficiencies created in the wards so that hopefully there could be better use made of

those beds. But at a time when the psych wards are on red alert and most of the patients are on diversion, I don't know even if you find yourself in this sort of program with patients that you find really need that sort of facility and don't have the beds that are available to refer them. It seems that the connection isn't as clear and as obvious and as easy as just closing one down and opening this type of unit up."

Mr. Fields: "I agree with you. Describing the efficacy and necessity for this idea is not wedded to the idea that it's funded by closing beds. But the money it takes to do something like this has to come from a capacity to find a large amount of funds even though the ADU beds are one-third the cost of inpatient beds. And so I can't speak to where Dr. Katz went in making his decision about how to fund it.

The system could do better. How about addressing that problem? I would argue if we'd addressed it eight years ago, five years ago, three years ago, and come up with back door discharge capability for the hospital, then there would not be people clogging up the beds that make it look like there's no room for an acute entry. There should be room for acute patients. If we could just move 20, 25, 50, we could keep those beds open for acute admissions, my argument would be they may have empty beds for a while. We're opening a new program that's a replication of Clay Street that is targeted at IMD clients that will open on October 1st. It's been sort of under the radar. The idea is to help the hospital have a community-based place to send people that are otherwise waiting to go to long-term care, to help take some of the pressure off. This will be a 14-bed program seeing patients on a regular basis.

I also think we have to do more to assess why people don't move out of the skilled nursing settings faster. We do know they sit there even more inappropriately for months and months when they should be back in the community. So it is a kind of movement game where the real solution would be a systemic solution. Do this urgent care thing, try to focus the hospital's capability on what it's designed to do and get people who are sitting there into the IMDs by moving people out of the skilled nursing into the community. There are some people there who could be in supported housing, let alone another 24-hour treatment program. So I'm not saying it's a direct connection but we've got to start somewhere and this is where the pressure point is. I believe that if we start now, while we're developing this alternative, to develop solutions with the hospital and the skilled nursing settings about emptying out those beds aggressively that we won't – by the time we open this new ADU with 14 beds, at least 14 acute beds will be available for more acute people in the hospital."

Dr. Shukla: "I guess that's my point exactly, is that there doesn't seem to be a direct connection; yet it's been made explicit that there is a direct connection, that the services that are lost through the closing of these beds will be in some way compensated for by the opening of these services. And I don't see that direct link. This seems like more preventative-based early acuity, and get these, patients that are just going in that direction safer, versus the higher acute locked bed patients that maybe are coming in and need that higher acuity but maybe at the back end need to go out and have placement that's better. And so I'm not sure that anyone's looking at that back end about the placement at the same time."

Mr. Fields: "They are. Barbara Garcia and Liz Gray are looking at it, and how fast it moves and whether it moves. But the only thing that I would disagree with is that this isn't preventive. Who's divertible at 8 o'clock at night out of PES when they don't have any beds left looks a lot different than who isn't diverted at 2 o'clock in the morning if there are beds available on the unit. That's a reality of our relationship with the hospital. If there's an open bed it's usually going to get filled, whether it's a new resident or a patient already there. So what I'm saying is we have the capacity to serve involuntary clients, but sometimes that's a specious distinction in terms of how acute somebody is. This new ADU staffing is much richer in the urgent care side, of course, than anything we have in our current acute diversion setting.

That I did not make the nexus and if somebody was misleading about that, it's only because the problem's more complicated; but I do believe that this program will have an impact on the number of people who would otherwise have been in PES directly that day. It's not just guessing who might be getting acute. This is diverting people. And that's why Mobile Crisis is pleased to have it because the only place they have to take people now is PES. And then there's a high chance that they might have waited long enough or the person's deteriorated enough that the only option is an inpatient bed at that time. And we're hoping that we'll head those very people off, 30% of them, to take the pressure off. That's the premise."

Mr. Purvis: "I just have a question about the voluntary nature of this. It would seem to me if you're bringing in people just before they're ready for 5150, they're coming in on a voluntary basis. But aren't there a lot of people who just refuse to come in and if so, how do you deal with that set of people, people who are unwilling to come in?"

Mr. Fields: "Well there are a number of complications to that. First of all, we fully expect to be receiving people who've been brought to us by the police who were held for transport on 5150. 5150 is a hold for evaluation methodology, as well as a post-assessment triage category, so that one of the things, the more subtle things, we're going to be working with the police on is bringing them here, and then we'll work with them and drop the 5150. That's the highest end of our intervention. The Acute Diversion Programs regularly deal with the resistance of going to any place at all and some people just won't go. But a lot of people do, and one of the things that's always made a difference, is that they see where the patients are going. The abstract is worse sometimes than the reality. So if they come into a place that's designed in such a way that it's meant to be inviting and responsive and done on a model, we find that involuntary decisions are sometimes reality-based decisions. I'm not going there voluntarily. And we're basing it on our experience in the ADUs along that line too. You put your finger on one of the issues that's going to have to be sorted out as we go into the next several months of actually planning the implementation of this program. Some of these questions aren't automatically easy to answer."

Mr. Purvis: "I've been dealing with this personally for years. Thank you."

Dr. Moses: "I want to firstly, commend the work Progress Foundation has been doing. My question is, with this new program you're proposing, how will you handle the revolving door issue, and also the program shelters, with people moving from one place to another? Do you have a plan for them on how to handle these kinds of situations?"

Mr. Fields: "On a resource level a revolving door in a step-down place takes pressure off PES, so we're contributing to the system. We're not going to worry too much about the revolving door except around the cost effectiveness of that being the only intervention. So to us, a revolving door, when someone comes back the third time, is an opportunity to insinuate a different choice in their life. It's a chance to engage the client sometimes when the first couple of times aren't as effective, if at all effective."

I would like to see more 24-hour options for people to continue structured rehabilitation and recovery, and we haven't really added any beds at that level of care in the system in a long time. I'm hoping one of the ways to use this new program that the Department has put a lot of energy into, is as a leverage point for getting these other resources, to say if you want this to work, we've got to have a place besides hotel rooms to send people to. But we're going to be in that system."

Ms. Kellum King: "The Mental Health Board had a lot of concerns about what was going to happen to people once the PES beds closed. We sent letters to Dr. Katz, and the Board of Supervisors. Just in terms of the process, people didn't really get back to us and respond to us very much at all. We had very little receptivity or communication about our concerns and in fact, I think we were told that we were misinformed but not really given very much other information."

Mr. Purvis: "Same with NAMI. We wrote letters and I've never got this type of explanation that you've given tonight."

Mr. Fields: "I apologized when I started about the fact that I didn't anticipate some of this. So what I will say is I was not aware of any of those inquiries for more information. If anybody had ever let me know NAMI had a concern, or the Mental Health Board had a concern, put aside the fact I should have thought of you, I'd have been at any meeting you needed me to go to. I think we have some work to do with CBHS and the Department of Public Health (DPH) about coordinating information, and not creating these misconceptions. Like I said, if we're going to have disagreements let's disagree about the facts on the table and not let you have to make up what you think you know and not get answers. So I apologize."

Dr. Shukla: "I just had a couple logistical questions in terms of where this urgent care would be located, what's the anticipated opening date and what sort of ancillary services like laboratory, urine tox screens, medications would be available?"

Dr. Nickens: "The Urgent Care Center will have laboratory services available, will have full medication services available and will be connected to the systems that Dr. Cabaj talked about that are electronic. These would give caregivers access to medical records of people being treated, so that their status could be assessed – what medications should be prescribed, do they have allergies, etc.?"

Dr. Shukla: "That's San Francisco General Hospital's medical records?"

Dr. Nickens: "It's the Department of Public Health records."

Mr. Fields: "We're looking for sites. Because we're attaching a residential treatment program to what's being termed a service or clinic model, there are zones that won't even

let us apply for a conditional use permit for the urgent care piece. We're looking at different sites now in the zones where we're able to at least get a use permit for them. So that has limited our search a lot and then it's just looking for the right kind of building. A building that's ready to be residential but needs an urgent care build out is one kind of problem. So we're in the middle of that right now, and we have three leads we're looking at. And our plan within the budget structure with a January 15th opening was optimistic. If we found a site by October 1st, it wouldn't be open before April 1st of next year, I believe. So I'm thinking we're looking at somewhere in April and May.

I'd be happy to come back and give an update on it. I'll talk with Ms. Brooke about it and answer some other questions that may remain so this doesn't end up being our last conversation."

Dr. Turner: "As you can tell, there's a lot of interest."

Mr. Fields: "Yes, absolutely. I depend on that"

Dr. Turner: "Thank you for your presentation."

Mr. Fields: "You're welcome."

2.2. Public Comment:

Dr. Leary: "I'm Mark Leary from the Psychiatry Department at SFGH. Mr. Fields, first of all, I want to echo what you said about the importance of our working relationship with the Progress Foundation. It's very important to us and we feel very good about it. Fortunately, all four of our community inpatient, and locked inpatient units are going to be kept open as far as we're being told. That's been confirmed, and we're very happy about that. But we are being told at the hospital that the bed cut is not going to be 14 beds, but 23 beds; so that each of the inpatient units would have 16 beds. So I wanted to make sure that that was clear. But I know throughout the whole budget process there's a lot of uncertainty about was it 14 beds, was it 21, 22, but that's the information that we're being given now at the hospital. I just wanted to clarify that.

And to echo our support, particularly for the Acute Diversion Unit part of it. I think we desperately need those additional resources. I'm hopeful about the Urgent Care Center, that it can take some of the load off of PES. I'm also happy to hear you say that, to repeat what Dr. Katz had said at one of the Health Commission hearings, that the beds wouldn't be closed until the services are open. Of course we would propose that the beds not be closed until the services demonstrated the need that the beds be closed; but we don't have that agreement at this point."

Ms. Fisher: "Pam Fisher, President of NAMI. We certainly have some concerns about this. We're very pleased with the thought of more beds in the community. We know that's a tremendous need. But we also fear that the County has lost hospital beds over the last ten years and this is just a continued drain. At the present we know that patients are sent out of county to locked facilities, PES is on red alert most of the time. Will these conditions change and if they don't change after six months or a year of the new program can we have some

promise that the beds will be restored to the hospital? I understand that's not a question you can actually answer.

Mr. Fields: "You're right. I cannot comment on that."

Ms. Fisher: "This is something that we are going to be watching and following very closely."

Mr. Martin: "My name is Fred Martin. I've been active in San Francisco affairs for over 50 years. I worked with Orville Lester and Percy Finkney in Youth for Service. I also served on the review panel; and I read virtually all of the County plans in connection with Proposition 63, and they simply failed to meet the treatment concerns. I think Mr. Fields has a good program. I would take nothing away from it. It's been around for a long time. But I think he did a Hail Mary and pulled the rug out from under some needed beds at San Francisco General, and I think we have to go back.

I have two cousins who are dead because of a lack of 5150s. I have another family member who's alive because of the 5150. The hearing officers in San Francisco, until we got the Behavioral Health Court, were never required to know anything about mental illness. That's true of all the counties and states. They don't have a Mental Health Court. And if you want to know the entry point for the chronically mentally ill, one of the symptoms of which is denial, and unless they get put into a 5150 they're not treated. And when I met with Willie Brown when I was doing the Mental Health and Public Policy Conference for the University of California, I said I think the majority of the chronically mentally ill are the chronic homeless. He said you're crazy. Virtually all of them are mentally ill.

We should be supplementing those beds. We should not be taking one of them away."

Noah: "My name is Noah. I'm a San Francisco citizen. I was questioning a statement you made earlier saying that you would have to extend the deadline from January, into probably June or October. What district is on your radar for the location of this facility?"

Mr. Fields: "It's not really districts as much as particular zones. I would say that on the eastern side and south of Market is our programmatic preference and that's where the predominance of those zones would be. We're not looking in the Sunset, the Richmond, the Marina, Chinatown, even the Haight."

Mr. Johnson: "My name is C.W. Johnson. I'm a mental health advocate with the Mental Health Association (MHA). I suffer from mental depression and schizophrenia myself. I suffered with a crisis not too long ago, where I've been to some of the hospitals around here. I also have been volunteering my services. And I didn't feel comfortable enough when I got into a crisis to even want to go to a hospital. So how is this, is this a preventive type thing where if you get to a point where you feel suicidal, you may feel so depressed where nothing's going good in your life and you just need some help, would this be that kind of place or are those kind of places being closed? Are those kind of beds being allowed for people, to prevent a suicide?"

Mr. Fields: "The short answer, Mr. Johnson, which isn't adequate, is no. The goal of this program is to target as much as possible for that high end, already at the edge of 5150.

We've got to prove that we can take that pressure off PES and do it or else, and that's the dilemma."

Mr. Johnson: "So it's more of a relief program, to relieve some of the overflow; to free up those beds there (SFGH-PES) so that you could help people before they get to that point?"

Mr. Fields: "Yes, that is the premise from which we are starting."

Mr. Johnson: "Thank you."

Mr. Fields: "You're welcome."

Dr. Turner: "Thank you Mr. Fields once again."

Mr. Fields: "Thank you everybody."

ITEM 3.0 Action Items:

3.1 Public comment relevant to Item 3.0

There was no public comment.

3.2 Proposed Resolutions

3.2.a PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of July 11, 2007 be approved as submitted

Minutes approved unanimously.

ITEM 4.0 Reports:

4.1 Report from the Executive Director of the Mental Health Board.

Ms. Brooke: "I will be on vacation September 13-30, 2007. Ms. Baltrip-Balagas will be handling things in my absence.

The next Police Crisis Intervention Training is October 22nd and the part in which any of you will become involved is October 23rd. That's a Tuesday. If you want to be on the panel you can call me after October 1st and we can talk about it.

I just want to make sure it's on your calendar that December 8th is the retreat. That's a Saturday.

James Keys brought to the San Francisco Mental Health Education Funds attention the desperate plight with the South of Market Childcare Center. The children there were scheduled to go down to the Monterey Bay Aquarium at 7:00 in the morning and were waiting for their buses, holding their little lunch bags that had been donated to the organization. The buses never showed up. So, they approached Mr. Keys. Mr. Keys called me concerning this, and I contacted Dr. Moses, who's Chair of the San Francisco Mental Health Education Funds, who made the decision to donate \$200 for lunches for the following Sunday so that they could go. I'm going to pass around a photograph of the

children I received after they went to the Monterey Bay Aquarium. This is not the total number of children, but this is some of them that benefited from our donation.

The Immigrant Rights Conference is happening on September 15, 2007, this coming Saturday. I think you received mail about that. Dr. Moses sits on the Immigrant Rights Commission. There is also a reception this Friday night.

There is a Suicide Prevention Workshop in Emeryville on September 21st. You've got that in your packet. I'm just calling attention to it. The California Strategic Plan for Suicide Prevention public workshops, just to take a look at that.

Finally, Ms. Kellum King, and I believe Ms. Lebish are going to the Substance Abuse Conference presented by CBHS. All conferences at CBHS are free, so if you want to go you've got a copy of that information."

4.2 Report of the Chair of the Board and the Executive Committee:

Dr. Turner: "I don't have a report tonight, per se. I sent everybody a letter to tell you all how much it's meant to me to be your Chair and just be a Board member for the past four years. So I just really wanted to address more of the emotional side and some of my sad feelings about leaving. I also wanted to let you know why I'm leaving a little early. I'm doing it because I've just been quite overwhelmed with work. I've taken on some new responsibilities in my job. Some of it has required me to travel and I've been away a lot so I just think it's time for me to move on.

I also feel like this Board is so capable and competent. It's just been amazing to me. I really appreciate your support, and I'm very excited for the future and where the Board is going. So you've all meant a lot to me. I don't want to not see you anymore. I plan on seeing people. I've been here for four years and the Board has turned over completely. I told Dr. Moses earlier, with the exception of him, the Board has turned over during my time. There are two people who left and came back – Ms. Kellum King and Ms. Brown. Others have come and gone like Benito Casados and Michael Medema, Rich Snowdon, Bob Douglas, Dorothy Schafer, Idell Wilson; there have just been many people who really left their imprint on me; and I think of you all at various times as you've shared your stories and it's just been a wonderful experience. So thank you for the privilege."

Ms. Brooke: "And we say thank you, Dr. Turner."

Dr. Moses: "I just want to also thank Dr. Turner for the wonderful job and contribution you have provided. I know when we harangued you to become Chair. You were very reluctant so I had to call you at midnight and say, 'Listen, I think you should take it.' And she has been doing a wonderful job since. You know, we really thank you for bringing us together and being involved. We're really sad to see you go, but you have to do what you have to do. So, we thank you very much for everything that you have done."

Mr. Purvis: "I just want to say we're going to miss you very much. You've been wonderful."

Dr. Turner: "Thank you."

Mr. McGhee: "As Vice-Chair, I want to thank you for taking the Board in directions it hadn't gone before. Some areas were risky, and your leadership had great impact."

Dr. Turner: "Thank you, Mr. McGhee."

4.3 Report by Members of the Board on Their Activities on Behalf of the Board.

Mr. Hines: "I'll be in Santa Barbara September 17th speaking at the 13th Annual Planning Association Suicide Prevention Forum. Tuesday, September 18th, I'll be speaking at St. Mark's Church in Los Alamos, and on the 19th, I'll be speaking at Allen Hancock College of San Maria and then back to Santa Barbara."

I just got back from Missouri, where I spoke at the Annual Suicide Prevention Conference over there and it was quite fruitful and a great learning experience."

Dr. Moses: "In addition to thanking the staff, we also have to thank you Mr. McGhee for using your influence to bring Assemblyman Dymally here, and the outgoing president of the Board of Psychology."

Ms. Kellum King: "I was able to attend the California Mental Health Policy Forum in Napa last week, and I found that there are so many states that are teaming up, forming unlikely alliances to help better mental health issues. Many of the things that we discussed tonight are things that they've already addressed."

Ms. Brooke gave me a proposal of an event that took place in Boston, the Boston Strategy, where everyone came together, put aside their differences and their egos to help address the killings and violence that were taking place in that city. I have started to touch base with the clergy in the southeast community. It's going to take all of us to address these issues. This is San Francisco, this is our city, this is our community, so I can't point the finger and say you do it, it's your part. No, it's for all of us. And I definitely have committed myself to see a positive change. I'm a part of the baby boomers, so I'm going to be booming for the better."

If anybody needs to call me about anything, there are a lot of conferences; that are up and coming so we can attend those."

Dr. Moses: "To echo what Ms. Brooke said earlier in her report, the Immigrants Rights Commission is having its conference. I am a commissioner and would like to have you come this weekend. The reception is Friday night, and the conference is Saturday from 8am to 4pm."

4.4 New Business

There was no new business.

4.5 Public Comment to Item 4.0

There was no public comment.

5.0 Election of Officers for 2007 to February 2008

5.1 Public Comment Relevant to Item 5.0

There was no public comment.

5.2 Report from Nominating Committee

Dr. Moses: "Madam Chair, thank you for the opportunity to Chair this Nominating Committee again. Ms. Williams, Ms. Brown, and I worked day and night to choose qualified candidates from the Board. I really thank them for the time they dedicated to this process.

For the position of Chair we have nominated James McGhee, who has been doing a wonderful job as Vice-Chair. For the position of Vice-Chair, we have nominated Dr. Jagruti Shukla. Mr. Keys is Secretary, and we ask him to continue in this position.

This is our slate."

5.3 Proposed Action: Election of Officers

Dr. Turner: "Thank you Dr. Moses, Ms. Williams, and Ms. Brown. I think it's an awesome slate and our nominee for Chair is James McGhee. I would like all in favor of James McGhee as Chair of the San Francisco Mental Health Board please say aye. All opposed, nay. The ayes have it. James McGhee is the next Chair of the Mental Health Board."

Mr. McGhee: "Well I want to thank Dr. Toye Moses, Ms. Williams and Ms. Brown for the honor of nominating me for Chair. As you all know, I take this Board very seriously and the people that we represent very seriously; so I accept this great challenge. I started four years ago, so thank you very much for the honor and opportunity."

Dr. Turner: "We have one more vote to take. The nominee for Vice-Chair, is Dr. Jagruti Shukla. All in favor say aye. All opposed say nay. Okay, Dr. Shukla, you are Vice-Chair of the San Francisco Mental Health Board. Congratulations."

Dr. Shukla: "I'm obviously honored that the committee thought of me for this position. I know I didn't respond to some of Dr. Mose's emails, at least initially, and, like Dr. Turner,

recently I've had a significant increase in responsibility at work. I was actually elected Chair of the Department of Primary Care for the entire County of San Mateo recently and also accepted for a two-year fellowship with California Healthcare Foundation for the future Healthcare Leaders of America. So, in addition to my role as Medical Director and a few of the other committees that I sit on, work has been overwhelming and I do take the work of the Mental Health Board seriously. I am really passionate about it and I think that it's important to take this new Board position; so, I'm very happy to serve as Vice-Chair. And I have some literally big shoes to fill. I'll strive to do that. Thank you."

Dr. Turner: "You'll get a lot of support. You just have to work on that executive team."

Dr. Moses: "I would like to thank LaVaughn King for all her guidance and all her help. She has previously served on the Board as both Vice-Chair and Secretary."

Ms. Kellum King: "Thank you Dr. Moses."

Dr. Moses: "The next elections will be in February 2008."

Ms. Brown: "The committee also wanted you know that we considered James Keys for Vice-Chair and the struggle there was that we couldn't have two public interests appointees be in the Chair and the Vice-Chair positions. I just wanted to acknowledge that he was a serious consideration to move up from Secretary."

Dr. Turner: "One person I will be seeing sometime is John Kevin Hines because he now works at Alliant."

Mr. Hines: "I got the job thanks to you, Dr. Turner."

Dr. Turner: "Thank you all again, and thank you, Ms. Brooke for four years of guidance and Ms. Baltrip Balagas also."

6.0 Public Comment

There was no public comment.

Adjournment

Meeting adjourned at 8:35 p.m.



SAN FRANCISCO MENTAL HEALTH BOARD

Gavin Newsom
Mayor

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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, October 10, 2007

City Hall

One Carlton B. Goodlett Place

2nd Floor, Room 278

6:30 p.m.

CALL TO ORDER

ROLL CALL

10-03-07FEB2:02 RCVD

AGENDA CHANGES

DOCUMENTS DEPT.

Item 1.0 DIRECTORS REPORT

For discussion.

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1.1 Discussion regarding Community Behavioral Health Services Department Report, a report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.

1.2 Public comment relevant to Item 2.0

Item 2.0 FAMILY MOSAIC PROJECT

For discussion.

2.1 Presentation: Family Mosaic Project, Janice Avery, MFT and Calvin Thomas, Outreach Coordinator

2.2 Board discussion of possible Board responses to the presentation.

2.3 Public comment relevant to Item 2.0

Item 3.0 ACTION ITEMS

For discussion and action.

3.1 Public comment relevant to Item 3.0

3.2 Proposed Resolutions

3.2.a PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of September 12, 2007 be approved as submitted.

Item 4.0 REPORTS

For discussion and possible action.

4.1 Report from the Executive Director of the Mental Health Board.

4.2 Report of the Chair of the Board and the Executive Committee.

4.3 Report by members of the Board on their activities on behalf of the Board.

4.4 New business - Suggestions for future agenda items to be referred to the Executive Committee.

4.5 Public comment relevant to Item 4.0

Item 5.0 PUBLIC COMMENT

Members of the public may address the Mental Health Board on any items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board.

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Frank Darby
Sunshine Ordinance Task Force
City Hall, Room 244
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SAN FRANCISCO MENTAL HEALTH BOARD



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Mayor

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UNADOPTED MINUTES

Mental health Board
Wednesday, October 10, 2007
City Hall, Room 278
San Francisco, CA 94102

DOCUMENTS DEPT.

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BOARD MEMBERS PRESENT: James L. McGhee (Chair); Jagruti Shukla, M.D., M.P.H (Vice-Chair); James Shaye Keys (Secretary); Jeanna Eichenbaum, L.C.S.W.; John Kevin Hines; Claudia Lebish; Toye Moses, Ph.D., M.P.H; Lisa Williams; Virginia Wright.

BOARD MEMBERS ABSENT: Bridgett Brown; LaVaughn Kellum King; Tom Purvis.

OTHERS PRESENT: Helynna Brooke (MHB Executive Director); Ayana Baltrip-Balagas (MHB Administrator); Robert Cabaj, M.D., Director, Community Behavioral Health Services (CBHS); Janice Avery, M.F.T., Family Mosaic Project; Calvin Thomas, Family Mosaic Project.

CALL TO ORDER

The meeting was called to order at 6:35 p.m. by James L. McGhee (Chair).

ROLL CALL

Ms. Brooke read the roll.

Item 1.0 DIRECTORS REPORT

Mr. McGhee: "Dr. Robert Cabaj will give the Director's Report for Community Behavioral Health Services (CBHS)."

Dr. Cabaj: "As I mentioned in my report last month, the Governor cut the AB 2034 funding out of the budget at the last minute. Services covered by these funds were kept in our budget, by Dr. Katz, through the General Fund. The Mental Health Services Act has some administrative dollars that they're going to give to the counties to fill the void left by the Governor's cutting of AB 2034 for one year. It's not a permanent fix. Eventually, a lawsuit may be pursued by the counties. A letter was sent to the Governor and Dr. Stephen Mayberg, Director of the California Department of Mental Health asking for a response, and demanding reinstatement of the AB 2034 money permanently. If this doesn't happen, a class action suit is going to be pursued. At this time, San Francisco is not directly involved. We'll keep you posted as this issue moves along."

Mr. Keys: "Is there anything that we can do, not only as a Board but perhaps with our Supervisors, to have San Francisco aid your department in successfully persuading the Governor to reinstate the funding?"

Dr. Cabaj: "I've been working with some of the Mayor's liaisons. They're interested in supporting us but they wanted to wait to see what goes on at the State level. I think it may be a little premature. Let's give the Governor a chance to respond and by some miracle he might restore the money. I doubt it. But then that'll let us know exactly what actions the State is going to take. If a class action suit is seen as needed, then we definitely can get that support. And what I can do is keep Ms. Brooke informed so she can inform the board. So it's a great idea but might be a little premature right now.

The other item in your packet I noticed was a stamped draft of our Workforce, Development, Education, and Training Committee's recommendations. I just wanted to be clear that this truly is a draft and is tied into the Mental Health Services Act education and training dollars, and it's just a proposed budget. There's supposed to be a written plan which hasn't been developed yet. The Committee met for a few months to come up with all the ideas of what San Francisco could do with this money. This draft is the list of everything. We don't have enough money to cover all these things. Plus, some of the things on that list would actually be covered by the State and some by the regional agencies. The Committee will reconvene to come up with the final list of prioritizations. And so what you've seen is a real early work in progress. We will thin it down and then match it to the likely dollars that we're going to get.

We are doing some renovations at 1380 Howard. I don't know if anyone's been there recently, but if you remember, the first floor used to be where the Department of Parking and Traffic was. We're hoping to convert this space into what we might call a Behavioral Health Access Center. We're moving the Access team for Mental Health and the TAP team, which is the Treatment Access Program for the substance abuse side there. This is allowing us to create a more integrated structure of services, and ties into our Integration mission. They're back reporting to me now directly, and they'll also report to Dr. Alice Gleghorn. We're also including some teams that are related to the court work, and we're expanding our pharmacy services. As people probably know, we have a pharmacy on the second floor. We'll be moving that down to the first floor to make for easier access and expand more room not only for more medication dispensing but also for morphine, methadone and substance abuse related services, which have been underserved. To make that change we need what's called the Proposition I, and the City hasn't had to do one for a while. We have many contractors that do Proposition I's, but a Prop. I is a public hearing that's held in front of the Health Commission that would talk about the pros and cons of such a move. We've notified neighbors, we have brochures going out in several languages. The meeting that will be held for the public comment at the Health Commission should be on November 6th. What I would like is the support of the Mental Health Board because you're actually our only official advisory group and any Proposition I hearing needs the support from the advisory group. The timing was very tight so we didn't have time to do a normal review and come back next month. So I was wondering if people would support our expanded services there and our expanded integrated services and give us support by a consensus vote. Ms. Brooke has written up a memo about it. It is in your background materials. And I think if you're willing to do a consensus vote today to support the memo, we can move forward. The timing is such that we realize, because we would be backing into the dates of the Prop. I hearing, we would need the Board's support in a very timely manner, i.e., today."

Mr. Keys: "What are some of the reasons for the proposed teams' move and consolidation? Is there going to be any change in services with the move?"

Dr. Cabaj: "Right now, the Access team does all screenings by telephone. There is no direct contact with the client. The new system would move the teams in and we will have direct evaluations so people can walk in and be seen, which I think is a much better evaluation and screening process. And we'll expand the Access team and TAP. The mental health and the substance abuse sides will work together, fully integrated, and I think this will help expedite people getting the services much faster. We'll also be able to do better work on getting entitlements. Let's say somebody has no insurance or no Medi-Cal but could qualify. We'll have an eligibility worker there who will be able to help people sign up and move much more quickly into getting insurance for qualified services. And then with the pharmacy just down the hall, it's going to make it very easy for people to get their medications. So I just believe the move is going to expand services we've provided in the past."

Mr. Keys: "Just in reading this over, this sounds fantastic. It appears that it will be a great boon to those who utilize these services. Yet I'm more concerned about the timing of you coming to this Board and asking for this. I'm not sure if it's even an emergency vote we need to take. What does the Sunshine Ordinance say? Should this item have been on tonight's agenda and sent out with the mailing a week before this meeting? I'm just concerned about that. And I believe that this is almost the second time that I think, something like this has come around. Well, if the rest of the Board is up to it, I will certainly go along, but I just caution the Board that we do need time to think these things through, to hear them in a reasonable amount of time."

Dr. Cabaj: "I appreciate that. I believe we're meeting Sunshine requirements with this process, and I know normally we would have a month's review. But as I said, we realized the timing was off. We haven't had a Proposition I hearing as I understand, in many years. We read the fine print and realized we needed support from our advisory group, but the Proposition I hearing was already scheduled. One public hearing is coming in the next week. It's on October 17th. And then the hard data's with the Health Commission. And they needed that day because the construction has to be started at a certain time. The space is cleared out but due to the construction they needed a fixed date. So that's why we got backed into this and I apologize. We only learned at the very end of the last week that we would need to do this procedure."

Mr. Keys: "Well I believe that we can have, if we all agree, an emergency vote and then we can hope to have this come up at a later date. But I believe for any type of hearings or meetings, or special votes that we've had to have it published a week beforehand to give people a chance who may want to come and speak to this Board or speak out about this matter. So we have not done that. But if Dr. Cabaj feels that we're not in violation of any Sunshine rules then I'm okay I guess."

Dr. Cabaj: "There'll be two windows for further comment from the public, both at the Health Commission itself on November 6th and one other time the date of which I will get to you. We put notices around the neighborhood. The public can write or contact us in between with comments. You can certainly review this at the next Mental Health Board meeting which will be after the Health Commission hearing; but there'll still be some chance to discuss it because the changes will take a few months to actually occur."

Ms. Brooke: "In the past, we've felt that a letter of support from the Board was not something that required being on the agenda, while a resolution would. What we might do this time, if the Board is in agreement, is do a letter of support and then actually put it on

our agenda in November as a resolution that we formally vote on. What we do today is essentially just a letter of support to go to the Health Commission. It's a gray area, Mr. Keys."

Mr. Keys: "I understand. I'm just, again, bringing it up."

Dr. Cabaj: "Going on with the rest of my report. On October 17th there's another public discussion about this matter at 1380 Howard, so there'll be another window for the public to comment. We've been working more on Trauma Focused Care. As a response to the violence in many communities and the onset of post-traumatic stress disorders, we've been doing more work using some national and local models. And actually since this report was written at the end of last week, we've been talking about looking at expanding some services to Visitacion Valley, because I know this came up in last month's meeting.

We're looking to see if we can do more traumatic stress response. We had a large meeting on September 27th. I was able to address over 220 new employees and people who started within our system in the last year. That includes the contracted agencies. We focused on the wellness-recovery approach of our system involving the consumer's family more. We really stressed creating a more welcoming environment in our treatment processes. And I think it was a very well received program. Ziaologic was here at the end of last week and did a lot of work on our program of integration.

Each month we give you an update on the Mental Health Services Act that's now fully in place. Rather than go through the details, it's written in the report here. It outlines the number of people we're seeing now and how many people are in the Full-Service Partnerships. You'll hear a little bit about some of the work we're doing with the Family Mosaic Project in their presentation coming up in a few minutes.

There is training coming up on The Villages. We hope The Villages is going to survive. As people know, that was funded strictly by AB 2034 money, so they were really in potential jeopardy if this budget cut went through. The Villages is in Long Beach, California and we really hope they will be fine.

We're going to be getting our planning costs for the prevention and early intervention money. The State finally released the guidelines. We'll be appointing a Planning Committee to help us look at what we could potentially do with the money here in San Francisco and see what other statewide collaboratives are going on. We are also focusing on suicide prevention. We've also been pushing people to join the Combined Charities Campaign. Unfortunately, the Department of Public Health has been the lowest contributor to charities throughout the City. We don't know why. We would like to increase our donations.

People may know the Stonewall Project, which is a methamphetamine treatment program. They have a new location on 18th & Folsom Streets.

Please review the report for announcements of upcoming events."

Dr. Moses: "Would you please give a brief summary of what's going on with the Change Agents program?"

Dr. Cabaj: "It's actually one of the most effective groups in our integration and substance abuse programs. We have over one hundred, and they meet regularly on a monthly basis to discuss their work with providers to better serve the clients."

Mr. Hines: "I first want to thank you for your hard work, and I know you've been working very hard. How is the peer training that's part of your Workforce Training efforts going?"

Dr. Cabaj: "We're hoping to create a certification program for peers and for family members who may not go through the formal training of a social work school at a university. This is very much up in the air. It looks like the State might fund this, so that's one of those items that we wouldn't have to put our own dollars toward. It's about how we can either create a training program that's more specific for peer employment or for family member employment. It's to expand the idea of new employees that wouldn't go through traditional training programs."

Ms. Brooke: "Former Board member, Benito Casados stopped by the Mental Health Board office today about this issue, and wanted to ask the Board to support more funding for Community Behavioral Health Services Workforce Training programs for consumers."

Mr. McGhee: "At this time I would like to take a consensus from the Board on writing the letter of support for Dr. Cabaj. Seeing we have a consensus, we will get the letter to you Dr. Cabaj, and thank you for your report."

Monthly Director's Report **October 10, 2007**

1. **Behavioral Health Access Center.** The San Francisco Department of Public Health, Community Behavioral Health Services (CBHS) division is proposing the creation of the "Behavioral Health Access Center." The Center will combine and coordinate several existing community services to improve access to behavioral health services for San Francisco residents. The Center will include expansion of CBHS pharmacy and Mental Health Access program services, and the relocation of the Treatment Access Program (TAP), the Centralized Opiate Program Evaluation (COPE), and the Outpatient Buprenorphine Induction Clinic (OBIC) at 1380 Howard Street. By centralizing these important programs in a single location, CBHS will be able to provide a welcoming and responsive environment for clients with behavioral health issues and to streamline access to integrated services. In addition, the Center setting will allow Mental Health Access staff to provide face-to-face assessment services as convenient in addition to the current telephone consultation model. The location of this array of services at 1380 Howard is an important step in providing truly integrated behavioral health care in San Francisco.

Community Behavioral Health Services invites you to a Community Information Meeting on Wednesday, October 17, 2007, 5:30pm- 6:30pm, 1380 Howard Street, 4th Floor Conference Room.

2. **Trauma Focused Care.** San Francisco is participating with a small cohort of counties in the "Trauma Focused Child Welfare & Children's Mental Health Services Project." The California Social Work Education Center, the Child and Family Policy Institute of California, the California Institute of Mental Health, and the National Traumatic Stress Network will partner with counties on the project. The National Center for Child Traumatic Stress also is a partner. Counties will implement the Child Welfare Trauma-Training Tool Kit and provide Trauma Focused CBT. The San Francisco Human Services Agency will train social workers in the principles of trauma focused treatment through a "train-the-trainer" model. CYF will provide Trauma-Focused CBT to children and youth. With the escalation of community violence in many neighborhoods in San Francisco, more children and youth have been impacted by traumatic experiences that significantly impact their development, behavior, and long-term emotional and physical health. The challenges these children and youth face are

compounded by involvement with the child welfare system through multiple placements and inconsistent care-giving relationships in the critical development years. For more information on this project, please contact Denise Jones, Assistant Director, CYF, at (415) 255-3403.

3. **CBHS System Orientation.** On September 27, CBHS hosted its annual System Orientation at the Ba'Hai Center. We welcomed over 220 new employees and interns into our system of care. Participants heard lively presentations about our vision of infusing welcoming in all that we do, particularly as we strive to improve access to services, further our integration efforts across our system, and actively engage peers in the recovery model. The 2007-2008 edition of the Organizational Provider Manual was unveiled, and additional hard copies will be made available by the end of October; they can be picked up in the 2nd floor supply room here at 1380 Howard. Electronic copies will be made available on our web-site shortly thereafter.
4. **CBHS Integration.** Zialogic met with Change Agents and other Integration Committees during their Quarterly visit on September 27-28. The new Integration CDs for FY 2007-2008 have been released. CDs include updated Integration materials and guidelines for the new fiscal year. If your program has not received a CD, please contact Kathleen Minioza at 415-255-3585 or email at kathleen.minioza@sfdph.org
5. **Mental Health Service Act (MHSA) Update.**

COMMUNITY SERVICES AND SUPPORTS (CSS)

From 7/1/07 to 9/30/07, 61 full service partners have been authorized to receive FSP services. Eight partners were discontinued from outreach efforts during this period due to inability to locate or having moved out of county. 280 full services partners have been authorized to date, with 177 of them receiving services within the last 60 days. Thirteen adults have received permanent housing (eight of them have found permanent housing through DAH) and twenty-three are in stabilization units. Seven applicants are awaiting approval of their permanent housing applications. Among Transitional Age Youths, seven clients have been housed and four remain on the waiting list. Hiring and retaining experienced and competent staff continue to be a major challenge for our CSS providers. Also, availability of affordable housing, especially for older adults in the FSP program and non-FSP clients, continues to be a hurdle.

MHSA IMPLEMENTATION SPECIALISTS' OBSERVATIONS ON THEIR THREE-DAY TRAINING AT THE VILLAGE

Five of our MHSA Implementation Specialists recently took a trip to Long Beach, California and participated in a three-day Immersion training held at The Village, in order to better acquaint and educate themselves on the principles of Recovery as practiced on a day to day basis in the services offered by this ground-breaking program. They learned about the Recovery model, which emphasizes hope, empowerment, and the self-responsibility of creating a meaningful role in life. Some of the breakout workshops attended included "Education Project," "The Art of Billing," "Housing First" and "Job Development and Support." Participants came from as close as Vallejo and as far away as Baltimore, to take the Immersion and learn about the program. The clients of the program, called members, were ever-present and helpful in every capacity as co-hosts to their guests. All in all, the entire trip was described as educational, fun, informative, and exciting. _

WORKFORCE DEVELOPMENT, EDUCATION, AND TRAINING

The latest meeting of the Workforce Development, Education, and Training Committee was held on Thursday, September 20, 2007, from 12:30 pm to 3:00 pm, 4th Floor Conference Room, 1380 Howard Street. The Committee discussed its first draft of budget recommendations with actual dollar estimations covering the areas of most mutual interest, according to the MHSA guidelines. These areas include Workforce Staffing Support, Mental Health Certificate Program, CBHS Training Initiatives, and Residency and Internship Programs. These preliminary figures are due to be revisited at a later date before final recommendations are submitted to the Executive Team for its approval and then to the State for its consideration and approval.

PREVENTION AND EARLY INTERVENTION

The State has released the final guidelines for county plan applications regarding the Prevention and Early Intervention component of the MHSA. For more specific information, visit the State website at:

www.dmh.ca.gov/mhsa/PreventionEarlyIntervention.asp If you are considering joining the planning committee and have not yet responded, please leave a message on the Prop. 63 phone line at 415-252-3084 or contact Kevin Ledbetter, MHSA Administrative Assistant, at 415-255-3513.

HOUSING

CBHS, along with its consultant, has met with the Mayor's Office of Housing and the San Francisco Redevelopment Agency to discuss the requirements of the MHSA Housing component and review projects that are in development or in the development pipeline. A stakeholders meeting is being planned for the end of October.

INFORMATION TECHNOLOGY

We are still soliciting for recruitment of consumer participants for the Planning Committee, to be initiated sometime this fall. To join, leave a message on the Prop. 63 phone line at 415-252-3084 or contact Deborah Vincent-James, Information Technology Manager, at 415-255-3635.

MHSA ADVISORY COMMITTEE MEETINGS

The Mental Health Services Act Advisory Committee meets bi-monthly from 3-5pm, alternating between advisory meetings and community forums. The next scheduled meeting are as follows:

Thursday, October 25, 2007

Advisory Committee Meeting

1380 Howard Street, 4th floor conference room

Wednesday, December 19, 2007

Community Forum

Location To Be Determined

6. **Combined Charities Campaign.** The Heart of the City Combined Charities Campaign is underway! You have the opportunity to really make a difference in your community to any charity of your choice for just \$1 per pay period! In addition to supporting worthwhile causes, you have a chance to win fabulous prizes! For every \$26 you contribute, you will earn one raffle ticket -submit your pledge form before October 15 to have a chance at the Early Bird Drawing at City Hall on October 16. If you are not a civil servant and are a contractor who wants to donate, you can write a check to the charity of your choice vs. payroll deduction. "Every Dollar Matters"! For more information contact your 1380 Campaign Captain(s) Kellee Hom 255- 3425, Jim Stroh 255-3445 or Campaign Coordinator Lucy Arellano 255-3687. Please visit <http://www/sfgov.org/charity>. Thank You!

7. **Announcement.** The Stonewall Project has new contact numbers. Our location and mailing address is the same: 3180 18th St @ Folsom, Suite 202, San Francisco, CA 94110-2042, but we have new phone numbers and email addresses:

New Telephone: 415.487.3100

New Fax: 415.558.9657

New TTY: 415.255.8842

The emails of all staff can be found on our website: www.StonewallSF.org

8. **Other Upcoming Events:**

MHA-SF Conference on Hoarding and Cluttering 2007 Progress Not Perfection: Improving Health, Safety and Comfort Through Harm Reduction – October 18th, 8:00am – 5pm @ St. Mary's Cathedral Conference Center, 1111 Gough Street

LA COSECHA: CELEBRATING 20 YEARS – This 20th Year Anniversary Conference and Celebration of Concordia Seminars will include workshops on issues such as immigration, substance abuse, youth & gangs, and depression. Various artists will also take the stage and express through their artistic works. October 19th, 8:00am – 5pm @ St. Mary's Cathedral Conference Center, 1111 Gough Street

Legal and Ethical Issues in Providing Mental Health and Substance Abuse Treatment in Multicultural Contexts – by Daniel Taube, JD, Ph.D., November 14th, 8:00am – 5pm @ St. Mary's Cathedral Conference Center, 1111 Gough Street

To register for these trainings, please contact Norman Aleman, CBHS Training Coordinator at 415-255-3553 or email norman.aleman@sfdph.org

Past issues of the CBHS Monthly Director's Report are available at: <http://www.dph.sf.ca.us/CBHS/default.htm> To receive this Monthly Report via e-mail, please e-mail kathleen.minioza@sfdph.org.

1.1 Public comment relevant to Item 1.0

There was no public comment.

Item 2.0 FAMILY MOSAIC PROJECT

2.1 Presentation:

Family Mosaic Project, Janice Avery, MFT and Calvin Thomas, Outreach Coordinator

Mr. McGhee: "We are pleased to have Janice Avery and Calvin Thomas from the Family Mosaic Project to talk about their program. Dr. Hannibal Lowry, the Executive Director of the program was not able to be here because he is on vacation. Ms. Avery has been with Family Mosaic for four and a half years. She is a marriage, family, and child therapist and received her education from San Francisco State University and the University of San Francisco, and specializes in child, adult, forensics, substance abuse and employee assistance. She supervises case managers and is the coordinator of the training program. She is also involved with the Outreach and Social Marketing program and serves on the management team. Calvin Thomas got his degree from San Jose State University. He has been with Family Mosaic since 1992. He is the Outreach Coordinator and a Care Manager."

Ms. Avery: "Good evening and thanks for inviting us to talk about our program. The Family Mosaic Project started in 1991 with funding from the Robert Wood Johnson Foundation. Mr. Thomas will give you some background information."

Mr. Thomas: "Family Mosaic evolved with a Robert Wood Johnson Foundation grant, in 1991. The Family Mosaic Project at that time was put in place in the BayView/Hunter's Point area to assist youngsters who needed intensive wraparound services. At that particular time, Family Mosaic was comprised of two probation officers, two Department of Human Services workers, two school district workers and mental health workers as well as the several advocates and secondary advocates.

The goal for Family Mosaic at that time was to not only to serve the BayView/Hunter's Point area but to serve greater San Francisco and to reduce out-of-home placement of youth. How did we do that at that time? There was a lot of infrastructure in working with day treatment facilities. Any youngsters who were misplaced in school, some of whom who had not had a diagnoses and who were put into different school settings were evaluated and assessed to make sure they were in their proper placement. We worked closely with the Department of Human Services caseworkers that are on our team. If a child had to be placed in a residential treatment facility, we needed to make sure the family was involved with that facility. Families need somewhere where they can do family therapy to make sure this youngster, when he completes the treatment and is ready to go home, he doesn't return to the same structure that contributed to the problems in the first place. Our goal is to work with the families. So in a nutshell, that's how Family Mosaic evolved."

Ms. Avery: "Ms. Brooke asked us to come tonight a give you a picture of the wraparound model, and I thought I could best capture that by presenting a case scenario. This case is atypical, because each client is a unique individual, but it's typical in terms of the issues that we face and the multitude of services that we provide.

So here's the case. I'll call the client "L." She entered Family Mosaic Project in November of 2006. She was a 13-year-old undocumented Hispanic female. She had been diagnosed at that time with depression disorder, cognitive delay and chronic kidney failure. She had a history of suicidal ideation and she had had one 5150 prior to our receiving her. She had been gang raped a year ago at her school. She lived with her mother, father, sister and 2-year-old brother who is also cognitively delayed. At that time she was running away for up to two days sometimes, and up to three weeks at other times. Upon her last three-week run she was not taking her medical or psychiatric medication. She was on a waiting list for a kidney transplant. It was alleged that she was using and selling drugs and that she was being sexually supported by older men while she was on the street.

While on the streets, she had a boyfriend at that time and in April he was murdered. They found him lying on the street. So this was her state we were presented with when she came into the clinic. This was the challenge we faced in terms of finding wraparound services for "L." Her mother refused to take her back at the house, and we had to put her in a foster home. The Family Mosaic team was comprised of a public health nurse, a family advocate, a psychiatrist, a family therapist, an individual therapist and a tutor. The care manager, therapist, psychiatrist were all Spanish speaking. She is currently now attending Galveston High. That happened last week. We provide the taxi vouchers to take her to attend her treatments three times a week. Our public health nurse, for example, took her to the appointment where she had to have some tests so she could get the dialysis treatments. The family is working on reunification and has started weekly visits with her. We're providing family therapy and individual therapy for her on a twice-a-week basis. She is stable and

attending school. We are working now to obtain the school program for cognitive delay. She's taking all her medications and this is just under a year after she showed up at our door. I was really impressed. I supervised the case but there was that one point where she was very psychotic and at the point she couldn't effectively communicate with us. I don't speak Spanish fluently and the parent was there but because, a clinical family advocate and the psychiatrist, and our clinical coordinator, who's also Spanish speaking, we were able to move past a critical point. I truly was impressed with that.

This case typifies the sort of wraparound services that we can and do offer families. We offer them whatever we can, whatever it takes. It could be things like this; or it could be as simple as music lessons. We do summer camps, we provide bus tickets, just a multitude of services. And because of the fact that we can't treat a child in isolation because each of them lives with the family or a guardian, we provide services as we can to all family members with the child. And typically they're not the only ones in the family who are having problems. They are just the identified patients.

Over the last year we've been really busy at Family Mosaic Project with integration efforts. We provide services to everyone—people that have Medi-Cal and those who don't. Before, we could only provide services for families who had Medi-Cal. Because of the integration efforts and the Mental Health Services Act (MHSA) funding, our door is the only door for many of these families. We also have begun the integration with the substance abuse component, as was talked about earlier. We do have a change agent in our program and someone asked a question about the change agent and I wanted to talk a little bit about that. That person in our program has been designated to make sure these things happen. She makes sure what services need to be in place get put into place

Mr. Thomas, as the Outreach Coordinator can speak more about our outreach efforts, but we have been trying, for example, this year to develop a partnership with the Treasure Island families, because they are San Francisco County residents and they are isolated. There are no mental health services on board at Treasure Island. So Mr. Thomas and I have gone out and started meeting with these families to figure out how Family Mosaic can provide services to these very needy families. We also are partnering with the neighboring schools as well. We've done individual therapy. I've done speeches to train teachers regarding post traumatic stress disorders and their affect on children."

Mr. Keys: "I think it's great that you are expanding your services to Treasure Island. I haven't heard anything about the Tenderloin and Market Street areas where we have gangs and children that are 8, 9, 10, getting ready to go into middle school that are facing different types of violence. You haven't mentioned a violence prevention program tied into what you've described here. Are there any type of preventative measures in place to reach kids, and work with families before these kids get to that point of violence? Is there a specific program that's in the works with Family Mosaic?"

Mr. Thomas: "Yes. You spoke of the Tenderloin area. I actually grew up in the Western Addition. With the Community Gun Violence Program, we serve greater San Francisco. A couple times I've done workshops and we work with different schools. I will go and speak with them. I will get various members in the community who have been non-productive in their youth and have turned their lives around to participate. I've grown up with some of these guys. Some of the ones I knew are deceased. They speak to youngsters about some of the things that they've gone through. I don't want the ones that have one foot in and one foot out of the gang life. I don't need those. I need the ones that are truly dedicated to making changes. I'll get them to go in schools. We work at Thurgood Marshall. I've gone over to the Presidio where I've done a group over there with youngsters who were having

a problem with Washington High School youth. In the Tenderloin area we really haven't hit it the way we should have and there's a lot that's going on. The Tenderloin has basically become a melting pot for Oakland, Richmond and everybody else. There's a drug war going on.

I'd like to say, and please don't take this in the wrong way. Generally, talk is cheap. Basically a lot of people go and talk to these kids. We have a program that deals with wraparound services. This would be an excellent opportunity to create a program where we could create wraparound services to catch these kids before they get to that point where they need to have somebody come and talk to them."

Ms. Avery: "We started working with a center in the Western Addition last year. Catching children early—at ages 4, 5, and 6—providing them with the needed services that would help in the prevention of violence. We're not funded for prevention, but we try to include some strategies in the community outreach work we do."

Mr. Keys: "You should try to partner up with CLAER Project because they have a couple of million dollars in the pipeline for crime prevention programs coming through."

Ms. Avery: "We work with CLAER Project as well. People from all areas of the City are eligible to receive services from Family Mosaic."

Mr. Thomas: "It's just a very good point that you're bringing up. I don't have an honest answer for that but unless we get out there and do the work, we'll never be able to collaborate with the other agencies where the need is."

Dr. Moses: "Well first of all I just want to thank you for hanging in there. I remember 14 years ago when I worked with Family Mosaic. I'm glad to see that you are still there. My question is am I hearing that you plan on relocating?"

Ms. Avery: "No, I didn't mean to indicate that. What I said is that we are providing outreach services to Treasure Island."

Dr. Moses: "You will keep your Bayview/Hunter's Point services and extend services to the families on Treasure Island."

Ms. Avery: "Right. We want to begin providing services to the families and schools on Treasure Island because the families are isolated."

Dr. Moses: "I had lunch with colleagues near Family Mosaic about a month ago and we were very impressed about your work. My question, what percent of your staff is on the City payroll? We were told that not everybody is on the City payroll, is that true?"

Mr. Thomas: "22 percent."

Dr. Moses: "And the rest of your staff?"

Mr. Thomas: "The rest are contract workers."

Mr. Hines: "I just want to say thank you very much for what you are doing and I understand that you're not funded to give preventative measures but you would like to. And we know that you're working really hard. I know for a fact that you're working extremely hard to do everything and you're doing it right and we appreciate it."

Ms. Wright: "I'm very pleased that you have a staff that speaks Spanish and they have a Spanish-speaking psychiatrist also. I think it's very important, especially in a Spanish speaking community. Some of the parents don't speak English and maybe the kids do but not the parents. What ages do you serve?"

Ms. Avery: "We're funded to serve ages 5 through 18. Most of our clients are between 9 and 15 years of age. We try to hire staff that speak the languages of people served. Spanish and Cantonese amongst these languages."

Dr. Shukla: "We've been hearing about funding going to specific groups and areas in the City, and not to other areas, in particular, Bayview/Hunter's Point has been one of the underrepresented areas. We're trying to figure out why more Requests for Proposals (RFPs) are received from some areas and not others. Agencies in Bayview/Hunter's Point seem not to be applying. This is what we have been told, that agencies aren't applying and that is why they aren't getting funded."

Ms. Avery: "Many of these agencies have experts working for them who know how to write grants. Anyone who has written a grant knows that it's all in the writing and documentation."

Mr. McGhee: "Based on what you're doing, it's a tremendous contribution to the youth you help save. It sounds to me that a consultation with a specialist in the area of writing grants and proposals could help. I happen to be a consultant for the SBA, the Small Business Administration, and we provide these types of assistance to non-profits. I can make a referral to someone at the SBA who could help in this area. It's a shame you don't have the funding to do more."

Mr. Keys: "There are some other areas to perhaps acquire funding. There is \$35 million marked for the South of Market area to improve the quality of life for the citizens in that area. They can give grants. Perhaps you can find out more about this. There is a housing clinic in the Tenderloin, the Tenderloin Housing Clinic (THC) that has monies that are set aside for youth programs, something that you could probably contact the Executive Director of this organization and see if you could patch into that money or collaborate with them in some type of way. There are a lot of things that you could be thinking about in regard to reaching out to some of those community based organizations that are trying to do more community based projects and work with them and patch into that money to help with your programs."

Ms. Avery: "What you all are talking about is on the level of a Proposition I. The City departments are the money brokers, the money handlers, the deal breakers. This is something we've been struggling against. I mean, it's not that we can't give them our feedback, but they're the ones who procure the money."

Dr. Moses: "I just wanted to follow up to what you said. If nobody from BayView applies for funding it's going to be really, really hard to get funding to agencies in this area. We're always asking Dr. Cabaj what is in there for BayView. The answer we get, is that no one has applied."

Ms. Avery: "It's hard to find out when the Requests for Proposals are going out. I don't have access to that information."

Mr. McGhee: "What we're saying is that we are aware of the problems that BayView has. So therefore we put a lot of pressure on Dr. Cabaj in reference to why isn't there more program funding going to the BayView/Hunter's Point area and CBHS continues to come back and say that no one applied for it. So that would tend to make us think that some community outreach needs to be done. We need to bring in the nonprofit agencies and do a workshop on proposal writing, grant writing, and I believe Dr. Cabaj made the comment that CBHS can't focus on one particular area because it may be viewed as favoritism. So we at the Mental Health Board could be the agency that would actually sponsor the workshops. I think Dr. Moses and the rest of us are saying that we're willing, as the Mental

Health Board, to provide support, to help the BayView/Hunter's Point nonprofit agencies elicit more funding,"

Ms. Avery: "That would be great."

Ms. Lebish: "My understanding is that Family Mosaic Group is not a full contract agency. You're one of the programs under the Children, Youth and Family Services."

Ms. Avery: "We're part of the Department of Public Health."

Ms. Lebish: "You're a separate contract nonprofit. Perhaps we can see if CBHS can find funding to help Family Mosaic with preventative services."

Ms. Avery: "There is room always for us to have more funds to provide preventative services."

Mr. McGhee: "We think very highly of your organization. And this I believe, is why we would like to be able to assist in any way by giving whatever advice or support we can."

Ms. Avery: "I just had a couple items to discuss in terms of our wish list. We've talked about one, providing prevention services. Another is to have the ability to address the housing issues that our County faces; and the third would be having more school resources. A lot of these kids are not in school for many reasons. So it would be nice to sit at the table with not only us, and the Department of Health Services, but also with Juvenile Probation and the Housing Authority. Also, our area represents the highest number of detainees at Juvenile Hall. We all have a piece in helping the children."

Mr. Keys: "Ed Lee over at the San Francisco Housing Authority (SFHA) would be the person to speak with. You also might want to try Supervisor Chris Daly. He's doing a supplemental for a 2008 ballot initiative that's going to create a pool of money for housing. Again it's another one of those thinking out of the box type of things, but you never know. You may be able to tap into that also. You can just contact the office and I'll get you in contact with the person working on this initiative and see if you could sit in on some of the meetings and get some input."

Ms. Avery: "Thank you."

Mr. McGhee: "On an annual basis, how many families do you serve?"

Ms. Avery: "140. If we become full, the number can go up to 200."

Mr. McGhee: "I want to thank you for coming on behalf of the Board. It's been very enlightening, and Dr. Moses has been trying to get you here for quite a while. Obviously, you see we're very committed in doing what we can on behalf of the Mental Health Board to help. Please feel free to call Ms. Brooke or me if we can be of help. But Dr. Moses, as usual, is always here to assist and help his community. He's a strong advocate for Bayview/Hunter's Point."

Mr. Thomas: "I'd like to thank the Board for having us also, and I really appreciate the comments and questions made tonight. Any time when an agency serves the public it should be challenged. But there also should be action. I'd like to see the Family Mosaic Project grab hold of providing preventative services."

2.2. Public Comment:

There was no public comment.

ITEM 3.O Action Items:

3.1 Public comment relevant to Item 3.0

There was no public comment.

3.2 Proposed Resolutions

3.2.a PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of September 12, 2007 be approved as submitted

Minutes approved unanimously.

ITEM 4.0 Reports:

4.1 Report from the Executive Director of the Mental Health Board.

Ms. Brooke: "Conard House has partnered with the clothing store TSE in a coat drive. You can donate coats at the store at 600 Maiden Lane.

The Police Crisis Intervention Training is coming up on October 22nd to the 25th. The 23rd is the day that family members or consumers can speak on the panel. If anyone's interested in doing that, please let me know.

Also, the California Institute for Mental Health (CIMH) is having a Crisis Intervention Team/Program Community Learning Collaborative Conference in Sacramento on November 2nd and 3rd. I've been invited to come talk about the San Francisco Police Crisis Intervention Training on the November 2nd. That's the Friday. They would also like it if a consumer or family member came to talk about their opinions about the police training and how it benefits consumers or family members. So if anybody is interested, we have to be up there by about 9:30 a.m, which means we have to leave around 7 or 7:30. Let me know."

Mr. Keys: "I remember the sweeps of the homeless on Market Street being done by the police. Are you addressing that in any way in your training?"

Ms. Brooke: "No, The training is really focused on providing information about mental illness to the police officers. That's the real focus.

CBHS is looking to recruit people to be on the Planning Committee for the prevention and early intervention component of Mental Health Services Act. So if you have any daytime available, try to attend. That's where they're going to be discussing the format of the use of the prevention money. So that's an opportunity to begin talking again about the need for programs like Family Mosaic to have prevention money, who are already working with families in the community."

4.2 Report of the Chair of the Board and the Executive Committee:

Mr. McGhee: "October is my first meeting as Chair, and I want to express my appreciation to the Board for electing me to this position. I think we've come a long way in regard to things we wanted to achieve this year. We've been more proactive. And I just want to say that as a member of this Board I personally think that we've accomplished a lot in the last year and we've got a lot more to do. But this has been a real exciting time. Hopefully we

can do more to represent our constituents. That's what drives me. I'm sure that's what drives you.

Kate Gillespie contacted us. She is the new Chair of the Marin Mental Health Board and she is interested in building a joint Board meeting in 2008. I believe Sunshine does not allow us to hold meetings outside of San Francisco County, but she thinks that they would be able to come here and do a joint Board meeting. We can discuss that at the Executive Committee meeting and then put that on the agenda for November so we can discuss it. We're talking about how the two boards can collaborate. Our Board is doing a lot of good things and they'd like to join us sometime in 2008. They're actually having their retreat October 13th, this coming Saturday, and she invited me to come to observe and participate. I told her if I could, I'd love to. The State Mental Health Board and Commissions Committee, on which you know I serve, is having our awards meeting in Sacramento on the 19th and 20th.

Thank you very much again for electing me your Chair."

4.3 Report by Members of the Board on Their Activities on Behalf of the Board.

Mr. Hines: "We had the Emeryville Suicide Prevention Action Network big conference a month ago. I attended with San Francisco Suicide Prevention.

Oprah Winfrey did two shows this month on bipolar disorder and her show reaches upwards of 20 million people every time it airs, so I was hoping that we could write a resolution of thanks for her show and to her personally. Both shows were very good, and I think Oprah Winfrey did a great service to the issue of mental illness by doing these programs, reaching that many people."

Mr. McGhee: "One thing that I would encourage you to do as a Board is really look at some of the events that are happening in the community. I think it's important when you can show up and people know who you are."

Ms. Wright: "I go once a month, to a support group for parents that have children with schizophrenia and bipolar disorder. I bring things from the Board and we discuss them."

Dr. Moses: "Firstly, I want to send well wishes to Board member Tom Purvis who is recovering from a fractured hip.

What is the status on filling the Board of Supervisors (BOS) seat on our Board?"

Ms. Brooke: "I've spoken with two BOS members, and one of them is thinking about coming on board."

Mr. McGhee: "There are two members with whom I can speak as well. I spoke with Supervisor Maxwell about serving on our Board, and she declined."

4.4 New Business

Mr. Keys: "I believe that we should look at writing a resolution to urge the Department of Public Health to create RFPs that are more enticing for smaller community-based organizations (CBOs) to have them apply for grants, and give them points that would help them out in the RFP process. We should bring this up in our next Executive Committee meeting."

Ms. Brooke: "The Executive Committee meeting is next Thursday, the 18th at 6:30 p.m at 1380 Howard Street."

Dr. Moses: "Is it open to the public?"

Ms. Brooke: "It is always open to the public."

4.5 Public Comment to Item 4.0

Ms. Accomazzo: "We are a group of Masters of Social Work students visiting from the University of California, Berkeley. Thank you for letting us observe the Mental Health Board meeting. Some of us are specializing in mental health, while others of focusing on health. I'm interested in Child and Family Welfare."

Mr. McGhee: "Thank you for coming You're welcome to come back and bring up issues your would like us to address."

4.6 Public Comment Relevant to Item 5.0

There was no public comment.

5.0 Public Comment

There was no public comment.

Adjournment

Meeting adjourned at 8:35 p.m.



SAN FRANCISCO MENTAL HEALTH BOARD

Gavin Newsom
Mayor

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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, November 14, 2007

City Hall

One Carlton B. Goodlett Place

2nd Floor, Room 278

6:30 p.m.

CALL TO ORDER

ROLL CALL

AGENDA CHANGES

Item 1.0 DIRECTORS REPORT

For discussion.

1.1 Discussion regarding Community Behavioral Health Services Department Report, a report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.

1.2 Public comment relevant to Item 1.0

Item 2.0 PRESENTATION: ACCESS

For discussion.

2.1 Presentation: ACCESS: Craig Murdock, Program Director, Lila Louie, Clinical Director

2.2 Board discussion of possible Board responses to the presentation.

2.3 Public comment relevant to Item 2.0

Item 3.0 ACTION ITEMS

For discussion and action.

3.1 Public comment relevant to Item 3.0

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3.2 Proposed Resolutions

3.2.a PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of October 10, 2007 be approved as submitted.

3.2.b PROPOSED RESOLUTION: Be it resolved that the Mental Health Board commends Oprah Winfrey for two shows about Bipolar Disorder.

3.2.c. PROPOSED RESOLUTION: Be it resolved that the Mental Health Board urges DPH to create an RFP process for smaller non-profits.

3.2.d. PROPOSED RESOLUTION: Be it resolved that the Mental Health Board urges CBHS to develop more programs in the Southeast sector of the City.

Item 4.0 REPORTS

For discussion and possible action.

- 4.1 Report from the Executive Director of the Mental Health Board.
- 4.2 Report of the Chair of the Board and the Executive Committee.
- 4.3 Report by members of the Board on their activities on behalf of the Board.
- 4.4 New business - Suggestions for future agenda items to be referred to the Executive Committee.
- 4.5 Public comment relevant to Item 4.0

Item 5.0 PUBLIC COMMENT

Members of the public may address the Mental Health Board on any items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board.

ADJOURNMENT

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Sunshine Ordinance Task Force
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1 Dr. Carlton B. Goodlett Place
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Telephone: (415) 554-7724
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SAN FRANCISCO MENTAL HEALTH BOARD



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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, November 14, 2007

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2nd Floor, Room 278

6:30 p.m.

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ROLL CALL

AGENDA CHANGES

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1.2 Public comment relevant to Item 1.0

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2.1 Presentation: ACCESS: Craig Murdock, Program Director, Lila Louie, Clinical Director

2.2 Board discussion of possible Board responses to the presentation.

2.3 Public comment relevant to Item 2.0

Item 3.0 ACTION ITEMS

For discussion and action.

3.1 Public comment relevant to Item 3.0

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3.2.d. PROPOSED RESOLUTION: Be it resolved that the Mental Health Board urges CBHS to develop more programs in the Southeast sector of the City.

3.2.e PROPOSED RESOLUTION: Be it resolved that the Mental Health Board approves construction of the Behavioral Health Access Program at 1380 Howard Street.

Item 4.0 REPORTS

For discussion and possible action.

4.1 Report from the Executive Director of the Mental Health Board.

4.2 Report of the Chair of the Board and the Executive Committee.

4.3 Report by members of the Board on their activities on behalf of the Board.

4.4 New business - Suggestions for future agenda items to be referred to the Executive Committee.

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MENTAL HEALTH BOARD ATTACHMENT A November 14, 2007

PROPOSED RESOLUTION (MHB-2007-xx): COMMENDING OPRAH WINFREY FOR HOSTING TWO TELEVISION SHOWS ABOUT BIPOLAR DISORDER.

WHEREAS, Oprah Winfrey is a well known and well-respected television host throughout America, and

WHEREAS, she has a strong reputation of presenting challenging issues that are of concern to many people, and

WHEREAS, Ms. Winfrey is very compassionate and very understanding of people with mental health issues or other problems, and

WHEREAS, Bipolar Disorder is a serious mental illness impacting 1.2% of the adult population with 25% attempting suicide, and

WHEREAS, onset is usually by age 30, sometimes later, and often slow to be diagnosed, causing fear and confusion in people struggling with this disorder, and

WHEREAS, 65% to 95% are stable between episodes, the rest chronically impaired, and

WHEREAS, Bipolar Disorder affects the entire family, not just the person with the disorder, and

BE IT RESOLVED, that the two shows hosted by Oprah Winfrey focused on Bipolar Disorder were greatly informative about this disorder, well thought out and very sensitive, and

BE IT FURTHER RESOLVED, that the two shows were very educational for people with little experience or understanding about the daily experience of a person with mental illness, and

BE IT FURTHER RESOLVED, that the shows put a real human touch to the disease and made it clear that this was a disease of the brain and not something you should just "snap out of", and

BE IT FURTHER RESOLVED, that the Oprah shows on Bipolar Disorder contributed greatly to an understanding of this disease by both those with the disease and others, and that it has led to people talking about the disease, and to internet blogs, leading to greater awareness of this disorder around the country, and

BE IT FURTHER RESOLVED, that the San Francisco Mental Health Board, and all people fighting for mental health awareness and education, thank you and appreciate you, Oprah Winfrey, from the bottom of our hearts for airing the two shows about Bipolar Disorder.

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MENTAL HEALTH BOARD ATTACHMENT B November 14, 2007

PROPOSED RESOLUTION (MHB-2007-xx): THAT THE MENTAL HEALTH BOARD URGES COMMUNITY BEHAVIORAL HEALTH SERVICES (CBHS) TO CREATE AN RFP PROCESS FOR SMALLER NON-PROFITS.

WHEREAS, larger non-profit organizations are applying for and being granted contracts with CBHS to provide services, and

WHEREAS, larger non-profit organizations have sufficient staffing to attend proposal meetings, and delegate appropriate staff to spend the time needed to complete the proposals, and

WHEREAS, larger non-profit organizations have developed the experience and expertise to respond effectively and successfully to the City's Request for Proposals, and

WHEREAS, the Mental Health Services Act sought innovative program designs and new ways of approaching mental illness, and

WHEREAS, follow up research by the Mental Health Association determined that front line staff was relatively unaware of anything new about the MHSA funded portion of their programs,

WHEREAS, smaller non-profit organizations might have new and innovative programs to offer, and

WHEREAS, smaller non-profit organizations often do not have enough staff to allocate the time necessary to respond to the City's RFP process, and

WHEREAS, the City's RFP process requires significant documentation, research, and proposal writing expertise, and

BE IT RESOLVED, that the Mental Health Board contends that many smaller non-profit organizations in San Francisco have developed innovative and creative programs that would significantly benefit people in the community if additional funding were available from the City, and

BE IT FURTHER RESOLVED, that the Mental Health Board requests of Community Behavioral Health Services that it develop technical assistance workshops, or provide staff capable of providing technical assistance for smaller non-profits to respond to requests for proposals, and

BE IT FURTHER RESOLVED, that Community Behavioral Health Services require larger non-profits to develop partnerships with smaller non-profits in order to be granted a contract for a proposal.



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MENTAL HEALTH BOARD ATTACHMENT C November 14, 2007

PROPOSED RESOLUTION (MHB-2007-xx): THAT THE MENTAL HEALTH BOARD URGES COMMUNITY BEHAVIORAL HEALTH SERVICES (CBHS) TO DEVELOP MORE PROGRAMS IN THE SOUTHEAST SECTOR OF SAN FRANCISCO.

WHEREAS, Community Behavioral Health Services has approximately 270 programs, a mix of civil service programs and contracts with non-profit organizations, and

WHEREAS, the Southeast sector of the City, comprising the Bayview Hunter's Point area and Visitation Valley, has evidenced serious issues with community violence and the mental health impact of that violence, and

WHEREAS, the Southeast sector of the City has a significant number of African American citizens which comprise nearly 25% of the people served by CBHS, even though African Americans number less than 10% of the City's population, and

WHEREAS, adults, families, children, and teens living in the Southeast sector have been actively seeking mental health services, and supportive living situations, and

WHEREAS, public meetings held to develop the plan for the Mental Health Services Act funding continually stressed the need for more programs in the Southeast sector, and

WHEREAS, of the 270 programs funded by CBHS, only 13, or 4%, are located in the Bayview Hunter's Point area and none are located in Visitation Valley, and

WHEREAS, of the 192 people served by the Full Service Partnership funding of the Mental Health Services Act, only 6 are known to be from the Bayview or Visitation Valley areas, and

BE IT RESOLVED, that the Mental Health Board urges Community Behavioral Health Services to actively outreach to the Visitation Valley and Bayview Hunter's Point areas of the City to determine what programs are needed in those areas, and

BE IT FURTHER RESOLVED, that the Mental Health Board urges Community Behavioral Health Services to outreach to the Visitation Valley and Bayview Hunter's Point areas to enroll additional people in the Full Service Partnerships, and

BE IT FURTHER RESOLVED, that Community Behavioral Health Services at the very least, to increase the funding to the few programs in the Bayview Hunter's Point area, so that these programs will be able to serve additional people.



SAN FRANCISCO MENTAL HEALTH BOARD

Gavin Newsom
Mayor

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@mentalhealthboardsf.org
www.sfgov.org/mental_health

**MENTAL HEALTH BOARD
ATTACHMENT D
November 14, 2007**

PROPOSED RESOLUTION (MHB-2007-xx): THAT THE MENTAL HEALTH BOARD approves construction of the Behavioral Health Access Program at 1380 Howard Street.

WHEREAS, the Behavioral Health Access Program at 1380 Howard Street will include expansion of CBHS pharmacy and Mental Health Access program services, and the relocation of the Treatment Access Program (TAP), the Centralized Opiate Program Evaluation (COPE), and the Outpatient Buprenorphine Induction Clinic (OBIC) at 1380 Howard Street, and,

WHEREAS, by centralizing these important programs in a single location, CBHS will be able to provide a welcoming and responsive environment for clients with behavioral health issues and to streamline access to integrated services, and,

WHEREAS, in addition, the Center setting will allow Mental Health Access staff to provide face-to-face assessment services as convenient in addition to the current telephone consultation model. The location of this array of services at 1380 Howard is an important step in providing truly integrated behavioral health care in San Francisco.

BE IT RESOLVED, The Mental Health Board of San Francisco is pleased to provide this letter of support for the proposed "Behavioral Health Access Center."

SAN FRANCISCO MENTAL HEALTH BOARD



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UNADOPTED MINUTES

Mental health Board
Wednesday, November 14, 2007
City Hall, Room 278
San Francisco, CA 94102

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BOARD MEMBERS PRESENT: James L. McGhee (Chair); Jagruti Shukla, M.D., M.P.H (Vice-Chair); James Shaye Keys (Secretary); Bridgett Brown; Jeanna Eichenbaum, L.C.S.W.; John Kevin Hines; LaVaughn Kellum King; Claudia Lebish; Toye Moses, Ph.D., M.P.H; Lisa Williams; Virginia Wright.

BOARD MEMBERS ABSENT: Tom Purvis.

OTHERS PRESENT: Helynn Brooke (MHB Executive Director); Ayana Baltrip-Balagas (MHB Administrator); Robert Cabaj, M.D., Director, Community Behavioral Health Services (CBHS); Craig Murdock, M.P.A., Director of Placement Services, CBHS; Lila Louie, L.C.S.W., Clinical Supervisor, Access; Rachel Ziering; Robert Douglas; Benito Casados; Bob Gimelli.

CALL TO ORDER

The meeting was called to order at 6:35 p.m. by James Shaye Keys (Secretary).

ROLL CALL

Ms. Brooke read the roll.

Item 1.0 DIRECTORS REPORT

Mr. Keys: "Dr. Robert Cabaj will give the Director's Report for Community Behavioral Health Services (CBHS)."

Dr. Cabaj: "Thank you. It's a pretty brief report. We've had a campaign for a while to make sure clinics are helping people with their entitlements, meaning if they would qualify for SSI and Medi-Cal, we want to make sure people get signed up. And there's been periodic resistance because it does take a lot of paperwork and the clients don't like to do it sometimes. We put a new incentive in with my calling them up, and we have some other interventions. We've had a goal of at least a 5% increase in people enrolled in each site and everyone made that goal this year, so we're very excited. We're going to see about whether we raise the goal or just find more means to help people. And what that really does is

benefit the client and the family because you get more access to services and care, and of course, this helps the revenue in the Department. So everybody wins in this situation.

Ms Wright and I were talking about the Behavioral Health Court. It's one of our most successful programs, and there's some really good data that came out in the *American Journal of Psychiatry* last month and there's a reference to it in here. It's exciting because what it did is show that clients who go through the Behavioral Health Court are much less likely to end up in jail again and much less likely to take part in a violent episode in the future. These are very important pieces of information and I was able to share that with Dr. Katz, our Director of Public Health. He was very excited about it and he shared with Mayor Newsom that the research article came out. Also, two days ago there was a really very nice article in the *Chronicle*, one of the most positive articles about any mental health and behavioral health related program in the City I've ever read. They seemed to be quite aware of the issues. It was a sensitively written article. I emailed Judge Morgan of the Behavioral Health Court, and said, 'Congratulations. It's nice to get such positive media coverage.' Judge Morgan told me that the Court is having its graduation ceremony and everyone's welcome to come. They do a group graduation every few months and it's actually tomorrow afternoon over at the court, either at 3:00 p.m or 5:00 p.m. I've been to the court a few times and it's very uplifting. People who haven't gone, I'd recommend just dropping by.

Moving on with my report. We really want to thank programs that have been involved with our Police Crisis Intervention Training (PCIT). As you know I think the Mental Health Board took the lead in helping to set this up a long time ago. Over 650 police officers have been trained. So they come by the clinics, they go to our residential programs, they go to our inpatient wards at San Francisco General Hospital. So we want to especially thank all the programs and the people involved because they make a big effort to be there, show the police officers around, and answer their questions. Some of the programs that we identified here in the report are Westside Clinic, the Sunset Clinic, the Chinatown Clinic, the South of Market Clinic, the Mission Clinic, the Tenderloin Clubhouse, and we used the organizations with the Adult Diversion Unit (ADU) programs: Progress Foundation, Ashbury House, La Posada, The Avenues, Courtland House and the Baker Street programs. So they have been just steadfast and I think a few of you went to do a presentation in Sacramento a few days ago."

Ms. Brooke: "Ms Brown went."

Dr. Cabaj: "I heard it was very successful. And people want to learn our strategies and buy our curriculum."

Ms. Brown: "They want me to be a traveler, too. I said, 'I can't do that.'"

Dr. Cabaj: "That's fantastic. I think the PCIT is one of the most innovative things we've ever done."

Ms. Brooke: "Mr. Hines, Mr. Casados, Ms. King, Ms. Brown and Mr. Douglas have all been panelists."

Dr. Cabaj: "It's good to acknowledge the programs because they do a lot to make this successful. I go to every one of the trainings, and I always learn something from the officers. They always have something to teach me. That's my favorite part of this great experience, so thank you.

We do a monthly overview of the Mental Health Services Act implementations and you can see the information here in the report. I won't go over it in detail because there's a lot of

information. I mentioned we're going to be working on the Mental Health Services Act's Education, Workforce Development and Training recommendations. That Committee is going to get together and come up with a set of priorities. And we're creating a work group to work on the new Prevention and Early Intervention Planning so we hope to get that up and running soon. It should be underway in January. Our regular bi-monthly Advisory Committee is coming up in December on the 19th. Seneca Center, which is over on 24th Street near Mission Street, is going to be the host site, so we want to feature the Mission District again because it's been a little while since we were there. There'll be another meeting in February, which is our regular meeting, at CBHS headquarters.

We usually list some of the trainings and the events coming up, and you can see there's a few related to consumer employment and retention. We're having families and consumers work together and Mr. Hines and others are going to be taking part in that, working with primary care and anxiety disorders. This conference is called "Motivating Families and Consumers: Sticking Together". Susanne Killing one of our nurse practitioners who's been running one of the groups for many years now for families will be working together with Mr. Hines on this conference."

Mr. Hines: "In the first piece of your written report you wrote that CBHS Mental Health Programs are designed to assist those applying for Supplemental Security Income (SSI). Are you planning on increasing the goal for the number of people you assist every year?"

Dr. Cabaj: "I would like to. We have a special consultant who helps us with the SSI work. We're going to see if she can spend a little more time on helping us expand our goals."

Ms. Brown: "I just think it's a good thing that you are helping people figure out what they qualify for, because some people go there and don't think they have any entitlements or any recourse for living expenses. So that's good."

Dr. Cabaj: "You're absolutely right. I think something like 60% of the people who work with us get their benefits, even after they've been turned down the first time, which I think is really important. You need persistence with these things."

Ms. Wright: "In the report you discuss funding for community services and partnerships, does this include housing?"

Dr. Cabaj: "It's a combination of the housing, intensive case management and the medication supports that we wouldn't have been able to provide prior to the Mental Health Services Act; so it is an increase but obviously, it's not nearly as many people as we'd like to serve."

Dr. Moses: "Dr. Cabaj, just for the record, as you are preparing your 08/09 budget, I just want to renew my request not to forget BayView/Hunter's Point that is desperately in need of substance abuse programs, especially residential programs."

Dr. Cabaj: "I appreciate that comment very much. Thank you."

Monthly Director's Report **November 14, 2007**

1. **CBHS Mental Health Programs Assisted on SSI Applications.** The results are in, and I want to express my appreciation to the 25 CBHS outpatient mental health programs who have all accomplished, and exceeded!, their FY 06-07 objective of assisting a minimum of 5% of their clients who are potentially-eligible-for-SSI to get help in

submitting applications for SSI income assistance. These 25 CBHS mental health programs worked collaboratively with Positive Resource Center, Disability Evaluation Assistance Program, and Homeless Advocacy Project, to help their clients apply for SSI. CBHS is committed to assisting and supporting our disabled clients in their applications for Supplementary Security Income and we want to congratulate all of you and recognize your efforts toward achieving this objective.

2. **SF Behavioral Health Court Shows Results.** A recently-published study, conducted by researchers at Langlely Porter Psychiatric Hospital, showed that mentally-ill offenders enrolled into San Francisco Behavioral Court (SF BHC) were 40 percent less likely to be charged with a new offense, and 54 percent less likely to be charged with a violent crime, compared with other mentally ill adults who had been booked in jail around the same time. SF BHC, which got started in 2003 without any extra funding, is a collaboration between Superior Court (Judge Mary Morgan), Public Defender's Office, District Attorney, Probation Dept., Sheriff's Dept., CBHS behavioral health programs (including the Forensic Program of Citywide Case Management), Jail Psychiatric and Aftercare Services, and other providers. SF BHC has been awarded new funding for a variety of innovative services from the re-established Mentally Ill Offender Crime Reduction Grant. An August 8, 2007 article in the SF Weekly shows an example of the wonderful work and accomplishments of SF Behavioral Health Court with a client, and can be read at <http://www.sfweekly.com/2007-08-08/news/breaking-the-cycle/full>. Another article featured in the SF Chronicle on November 12, 2007 shows how Behavioral Health Court offers hope and help to those in need. This article can be read at <http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2007/11/13/MN3ST0DCQ.DTL>

3. **Special Thanks to the Programs that support Police Crisis Intervention Training.** October 22nd to October 25th was the 23rd Police Crisis Intervention Training. The training was developed in 2001 by a joint committee of mental health staff, Mental Health Board members, consumers, advocates, and police officers all working together. The 40 hour course provides training in recognizing signs and symptoms of mental illness, information about available community resources, and specific crisis intervention and de-escalation techniques. The second day of the training consists of visits to programs representing different levels of care: clinics, ADU's, and inpatient units. We want to give special thanks to the many people and programs who have conducted tours for the police officers and facilitated interactions with their clients. Some people have left CBHS and others have moved to other programs within the system but we wanted to recognize everyone who has participated.

Westside Clinic with Ruth Bertrand and Muna El-Shaieb
Sunset Clinic with Terry Wong and Raul Reyes
Chinatown Clinic with Wilma Louie
South of Market Clinic with Mabel Jung
Mission Clinic with Manuel Vasquez
Tenderloin Club House with Cingy Gyori and Tim Mason

Progress Foundation programs such as Shrader House with Frank Schultz and Stephanie McDowell
Ashbury House with Alissa Burgy

La Posada with Brian Couture
The Avenues with Ying Zhang-Chiu, Karen Brooks, and Lisa Rachowicz
Cortland House with Rosana Martinez
Baker Street Program: Robertson's Place with Angela Sun and Lornetta Major

During the first few trainings, Mozeita Henley gave tours of the Mental Health Rehabilitation Facility, and then we started going to San Francisco General Hospital where Troy Williams presented about Psychiatric Emergency Services and Sharon McCall Witcher and Cathy Balou gave tours of the inpatient units.

This is a very important part of the training and officers consistently evaluate their experience highly. We hope that it helps increase communication and collaboration between CBHS and the SFPD.

4. Mental Health Service Act (MHSA) Update.

COMMUNITY SERVICES AND SUPPORTS (CSS)

284 full services partners have been authorized to date, with 194 of them receiving services within the last 60 days. All programs, but one, have exceeded their targeted unduplicated client count. All in all, we are proving successful in identifying clients although locating some of them has proven to be a challenge. Eighteen adults have received permanent housing (ten of them have found permanent housing through DAH) and twenty-four are in stabilization units. Four applicants are awaiting approval of their permanent housing applications. Among Transitional Age Youths, seven clients have been housed and three remain on the waiting list. This group tends to be more unpredictable in acquiring and maintaining permanent housing, requiring more intensive coordination between the personal service coordinator and the housing manager. 949 clients have utilized our services provided by General System Development programs. The array of services includes housing support, socialization activities, holistic health alternatives, outreach and referrals, and vocational assistance. Support is also provided for trauma victims and victims of violence, especially in neighborhoods impacted with higher incidents of community violence.

HOUSING

Negotiations are currently underway with the Mayor's Office of Housing and the San Francisco Redevelopment Agency to come up with viable projects and develop an RFP/RFQ for agencies interested in applying for the housing monies being released by the State this year. We held our Community Stakeholders Meeting on October 30, 2007, which was well attended by various parties interested in knowing the requirements of this MHSA component. Several focus groups targeting the four age groups are currently being facilitated by Mental Health Association of San Francisco. The adult group, held on November 1, elicited lively feedback from participants encompassing varied residential backgrounds, ranging from support hotels (SRO's), to assisted living residences, to independent living arrangements. Other targeted focus groups are scheduled for November 14 (TAY), November 15 (Families), and November 26 (Older Adults).

MHSA ADVISORY COMMITTEE MEETINGS

The Mental Health Services Act Advisory Committee meets bi-monthly from 3-5pm, alternating between advisory meetings and community forums. The next scheduled meetings are as follows:

Wednesday, December 19, 2007
Community Forum
Seneca Center, 2513 – 24th Street
San Francisco, CA

Thursday, February 28, 2008
Advisory Meeting
1380 Howard Street
4th Floor Conference Room

5. Other Upcoming Events:

STRATEGIES FOR CONSUMER EMPLOYMENT AND RETENTION, AND FOR THE CREATION OF A WORKER FRIENDLY ENVIRONMENT IN THE BEHAVIORAL HEALTH WORKPLACE with Sharon Kuehn and Katrina Killian – November 30, 2007, St. Mary's Conference Center, 1111 Gough Street, San Francisco. This conference goes beyond the rhetoric to actually provide much valuable *practical, useful, specific, direct advice* on the how-to's of maximizing the benefits of hiring, supporting and promoting consumer employees at your CBHS agencies, including pro-active steps to address hotspots and challenges, cultivation of a great work culture, and implementation of practices and policies that have worked.

MOTIVATING FAMILIES AND CONSUMERS: STICKING TOGETHER with Susanne Killing and Kevin Hines– December 7, 2007, St. Mary's Conference Center, 1111 Gough Street, San Francisco. This training is oriented towards helping consumers and their families assist and support each other when addressing mental illness and substance abuse.

SAVE THE DATE: ANXIETY DISORDERS IN PRIMARY CARE -- "Anxiety Disorders in Primary Care: A Practical Approach to Diagnosis and Treatment," is the theme of a day-long conference scheduled for Thursday, January 24, 2008 at the Mission Bay Conference Center at UCSF. On-line registration will be available after November 12 at <http://www.sfdph.org/dph/comupg/oservices/mentalhlth/cbhs/>. The target audience is staff working in the Primary Care, Emergency Medicine, Substance Abuse, and Mental Health fields. For further information, contact Kathleen Minioza at 255-3585 or email at Kathleen.Minioza@sfdph.org. Conference admission is \$85 and includes CME/CEU. Pre-registration required.

To register for these trainings, please contact Norman Aleman, CBHS Training Coordinator at 415-255-3553 or email norman.aleman@sfdph.org

Past issues of the CBHS Monthly Director's Report are available at: <http://www.dph.sf.ca.us/CBHS/default.htm>. To receive this Monthly Report via e-mail, please e-mail kathleen.minioza@sfdph.org.

1.1 Public comment relevant to Item 1.0

Mr. Gimelli: "My name's Bob Gimelli. I was just wondering, could I get a list of who these providers are that have been assisting people with SSI?"

Dr. Cabaj: "It's everybody in our system. So the simple answer is every clinic and every service in our city that contracts with us. Any Civil Service clinic that provides direct care has been given this training."

Mr. Gimelli: "Does this include primary care clinics?"

Dr. Cabaj: "No, only the behavioral health clinics. That's a very good question. We are going to move into the primary care clinics. They have a separate target. I don't know their percentage but they're also trying to make sure people receive the enrollments and entitlements that they should be getting."

Mr. Gimelli: "The reason I asked is because I got disability coverage through SSI, and the worker who assisted me told me that they have about a 90% batting average. It was a very easy process for me."

Dr. Cabaj: "That's good to hear."

Mr. Keys: "Thank you Dr. Cabaj for your report."

Mr. McGhee: "I apologize for being late, and thank you Mr. Keys for starting the meeting."

Item 2.0 Access

2.1 Presentation: Access: Craig Murdock, Director of Placement Services, CBHS, Lila Louie, Clinical Supervisor

Mr. McGhee: "We are pleased to have Craig Murdock, Program Director for Access and Lila Louie, the Clinical Director for Access here tonight to describe how they assist people with connecting to services provided by Community Behavioral Health Services, and what changes there might be in the future when the first floor of 1380 Howard Street opens up to face-to-face services by Access. We would appreciate it if each of you gave a little background information about yourselves."

Mr. Murdock: "Thank you and good evening. Thank you for having us. My name is Craig Murdock with the Department of Public Health, Community Behavioral Health Services (CBHS). I am Director of Placement Services for CBHS. And to my left with me is Lila Louie. She's the Program Coordinator for the Mental Health Access team."

I've been with the department for about eleven years. I worked in and around, above and below 1380 Howard Street for that entire period of time in various capacities. I worked in administration for a while as a Program Manager on the substance abuse side. And then I later went to the Community Programs Placement Division under the directorship of Liz Gray. And now I'm working in CBHS directly with Dr. Cabaj and Dr. Alice Gleghorn."

As the Director of Behavioral Placement Services, I have purview over five different programs, one of which is the Mental Health Access Program. The others are the Treatment Access Program (TAP), the Proposition 36 Program, Drug Corps, and the Behavioral Health Court, the last three of which are exclusively criminal justice oriented programs. It's only as recently as August 1st of this year that all of these programs were incorporated and integrated into Community Behavioral Health Services. Prior to that, they were part of

Community Programs Placement under Liz Gray. But for the purposes refocusing and reinventing the way things are done with the outreach practices, and providing direct access to services in our system, the decision was made to move these programs into CBHS and collocate them and relocate them at 1380 Howard Street on the first floor. I know that the purpose of this meeting is so that we can present you with an overview of the Access Program, which Ms. Louie's going to do, and then after that I can maybe go into a little bit of detail as to what is happening and what has happened as far as the collocation at 1380 Howard."

Ms. Louie: "My name is Lila Louie and I've been in San Francisco Mental Health since 1990. I was a case manager, and went on to Citywide Case Management, then South of Market. I've been with Access since its beginning until now. It's been ten years.

Mental Health Access is the realization of managed care in the mental health sector. The State mandated that every county set up a mental health access line. It's a 24-hour line that has to be answered by a live person to help link clients to mental health services. We did staff it actually 24 hours for a period of time and we found that the volume of calls did not really justify the staffing we had. Messages are taken and we return those phone calls the next workday. We have on staff right now eight people. That number has shrunk quite a bit from the 15 staff we had at one time. We're down two staff currently. The clients call in, not just people asking for information, but family members, community people, M.D.s. We get calls from neighbors, and a lot of different people call us to ask for information as well as asking directly for mental health services. I just want you to know that these are outpatient services that the Access line is set up for. When some clients call in, we try to find out if they live in San Francisco. Services are for San Francisco residents only. We're also doing a financial screening to find out if they're on Medi-Cal or if they're on some type of insurance. We have access to Cal-Med, the State Medi-Cal. We need to verify that they do have Medi-Cal and that it's from San Francisco. And if it's not and they just moved here, we'll help direct them to how to get that switched over. Or if they're leaving the county, we also give them information about how to take their insurance with them.

This is a licensed clinical with Master's level staff. There are some crisis calls that come in and we handle those as well. In the screening, we're trying to figure out what kind of services they're wanting, what kind of services they need. We're triaging them to one of the clinics that are located in the three neighborhoods in the City. These are for clients that need some more wrap-around services, case management services in addition to medications. And the other option is the private provider network: of private psychiatrists and therapists who have contracted to work with us. For clients that we feel can be seen in a private office, we will authorize that they be seen by a psychiatrist. It also includes family therapy and couples therapy. That's generally what the team is doing."

Mr. Murdock: "The Access team plays a very, very important part in being that portal of entry into the overall system of care, which we all know is large and cumbersome and oftentimes very unwelcoming, or it has a perception of being very, very unwelcoming. So what Mental Health Access endeavors to do is to provide a comfortable, confidential space for patients and clients to enter into our larger outpatient system of mental health services. Again, the services are offered 24 hours a day. After hours the calls are referred to Suicide Prevention, who will engage the patient and forward that information to the Access team so that they can get the patient engaged in some sort of treatment regimen. So that's the Mental Health Access Program."

Ms. Brown: "How late does somebody get to talk to a live person?"

Mr. Murdock: "24 hours."

Ms. Brown: "I mean, without going to Suicide Prevention?"

Ms. Louie: "8:00 a.m. to 5:00 p.m., Monday through Friday."

Mr. McGhee: "When a person calls in and needs to see a psychiatrist and they are on Medicare on Medical, does that present a problem?"

Ms. Louie: "We're looking in the State Medi-Cal records to see if the patient has Medi-Cal. Now if a person has Medicare, in addition to Medi-Cal, it will show up in the State records. If a person has Medicare only, it may not show in the State records at all. It's the Medi-Cal system, not Medicare that we are looking at. The clinics see Medicare clients if they're appropriate for that level of care."

Mr. McGhee: "What do you mean when you say 'if they're appropriate'?"

Ms. Louie: "For the clients who need wraparound services; who need case management services."

Mr. Murdock: "Medication, intensive services."

Ms. Louie: "For clients that have Medicare, the way the insurance works is that Medicare is primary to Medi-Cal. Medi-Cal is the payer of last resort. So if someone has other insurances, some people could have private and Medicare and Medi-Cal, that's the order that the insurance gets used: private, Medicare and Medi-Cal. If it's Medicare and Medi-Cal, then that's the order, Medicare and then Medi-Cal. So if someone has Medicare only or Medicare and Medi-Cal, but is slightly higher functioning and doesn't need the case management services, Access is not responsible for authorizing those services. We could find a private Medicare accepting provider for that person."

Mr. Murdock: "If they're on Medicare and they're in need, we can refer them to the clinics if that level of care is warranted. If they need in addition to therapy, medication management, or intensive case management, we can authorize that they receive services at the clinic and Medicare will be billed. However, if the individual does not warrant that level of care for whatever reason, or that level of care is appropriate but the patient refuses or denies acceptance of that level of care and Medicare is their only option in terms of paying for treatment, then it's incumbent upon that individual to locate their own therapist in the community who is Medicare approved. There are a little over a hundred of them here in San Francisco. The provider needs to be willing to take new patients."

Mr. Keys: "It sounds as though when a person calls up they are probably in crisis, wouldn't you say? Yet they may not meet your level to assist them, and you're then pushing them away and asking them to go out and find their own doctor."

Mr. Murdock: "Not if they're in crisis."

Mr. Keys: "Anyone who's calling in could be considered in crisis because they're calling up for help. They may be at the beginning of it, they may be in the middle of whatever type of issue that they're in, yet all of a sudden they're getting a 'we can't help you; you have to find your own help', which I don't find to be very comforting or very consumer friendly. I called the Access line three times recently. I called last week and I called twice today, and beyond their recorded greeting that I got, which I found was really great, you did it in different languages, and I found that was really wonderful; however I never spoke to anybody any of those three times and I had to wait on the line for more than five minutes. I felt that was certainly not something that could help me. I have been in trouble before, and

I have called out for help before, and if I was still in that type of situation, I don't think that being on hold for at least five minutes would be very helpful. So is there something that you can tell me about the length of wait that a client would have before speaking with a person? I had a wait of more than five minutes each time I called."

Ms. Louie: "We are down-staffed right now. Like I said, we had 15 staff and right now we have eight. We're trying to hire one person but we lost several positions; so that's something that I've been trying to fight for in terms of getting the staff to the numbers that we should have to be able to take care of all the calls. But I do want to say that we do handle our calls very carefully. We're very diligent in that we are asking all the questions that we can to really find out if someone's in crisis. We do not turn anyone away who's in crisis. Whatever situation that they're in, whatever insurance they have is irrelevant. I just want to be sure you understand that."

Mr. Keys: "We want to make sure that you understand that we're not trying to single you out or put you on the spot. We're asking these questions because we want to help. We want to advocate for those people who may find themselves in a situation where Access is one of the phone calls that they make. But we want to be able to make sure that these people are going to get the right type of care or that they can at least be referred in a friendly, positive and speedy manner so that they can get that help before they escalate any further."

Mr. Murdock: "It would be extremely helpful if we were able to establish a full staffing pattern. As Ms. Louie mentioned, we're down to eight full-time employees. Many of our positions were grant funded and that grant has since ended, and is no longer paying for any more positions. The Department and the City decided not to backfill those positions with the General Fund, so we essentially lost those positions. We have one position that is vacant right now, and are getting ready to offer it to a person already working in the department. That coverage almost didn't happen because we found out that the funding source for that position was compromised this budget year. So now we have two vacancies with a resignation that is about to happen next week, which we will be working very hard to fill. But right now, we are down to eight full-time employees. That is what we have budgeted on the Access Program's books. So as the level of effort increases, obviously workload issues come into play and it's not every minute of every hour of every day that someone's going to be able to answer the call, especially if the clinicians are off handling calls at the same time. So that's an issue that has been ongoing and that we are trying to rectify right now. We did put in an immediate budget request for another position for January, and that position has already been turned down. So right now we're looking at eight staff for the rest of this year and possibly even next year. So that's kind of the reality with which we're working right now. We have finite resources to actually pay the clinicians to provide the service."

Dr. Shukla: "What volume of calls that relates to what we're talking about do you get in a day?"

Ms. Louie: "Between 80 to 100 calls."

Dr. Shukla: "Do you have any mechanism for evaluating how well you're able to assist those 80 to 100 calls in terms of how many were actually then plugged into a clinic or a provider, and in some way, an evaluation of how effective the references are in terms of the patient actually making an appointment and going there? I think a lot of what I'm asking about is the next steps. So once the patient's triaged, it's determined that they're going to go to a clinic or they're going to go to the private provider network, do you have any ability to assist them in making that appointment or contacting that clinic and saying we

have a referral; we want to fax you this person's information, or some loop that gets closed? Or do you just tell the person here's the clinic name, address and phone number and then hang up, and then that person's on their own to call and make an appointment? Sometimes it takes a lot of savvy to navigate the system and actually make an appointment as a new client."

Ms. Louie: "Clinics have different intake setups, so some clinics have actual appointments and we call and get the appointments for them. Other clinics will have drop-in hours. The system has evolved and changed."

Mr. Murdock: "It's actually gotten better."

Ms. Louie: "Yes. It used to be all appointments had to be made, and clinics found that there were all these no-shows and it really compromised their ability to utilize the staff time. So they would have this hour and a half X'd out and no one show up. They found that having these open times for clients to drop by, and just come in to be seen worked better. We don't have a system to follow up to see if they made the appointments or not. But I do know that the Access staff will call the clinic or call the client just to check in with them. So that's something that is done unofficially."

Mr. Murdock: "We can query the Billing Information System (BIS) system to see that they've in fact gone to their appointment and then engaged in treatment. What we don't have the capacity to do is to find out or ascertain how soon after they may have stopped coming or discontinued treatment. We can verify that they did in fact go to the program and actually were present to receive services. All of this is going to change come January. In a minute, I'm going to talk about the collocation of 1380 Howard Street. It's going to change things quite radically."

Ms. Brown: "You talked about if the clients had Medi-Cal or Medicare. What if a person came in and didn't have any insurance? Would they still get services, and would you be able to make sure they had aftercare even after they went for that one day?"

Ms. Louie: "If they don't have insurance, depending upon their income, they receive services at a sliding scale. They don't get turned down."

Mr. Murdock: "If they have no insurance or income source at all, treatment is not based on the ability to pay. Sliding scale means that it slides down to free, if you don't have any income. So no one is turned away for lack of income."

Ms. Kellum King: "Today my son made three calls to the Access line. He said, 'Mom, they just passed me from one person to the next.' And I said, 'Well let me give it a try.' And he's in crisis right now. Normally he's at these meetings with me. I got a very pleasant person but I didn't get any real information. She didn't have the information I needed in front of her. I was just as confused as my son was. So I would like to hear about the proposed change. Thank you."

Dr. Shukla: "Do you think the fundamental problem for the delay is a staffing issue or is it a lack of information or a lack of power to let these patients in? With more staff, would your team be more effective? Because right now Access is just a network of information, right? I mean, people call and say, 'Where do I get services?' You don't actually offer services."

Mr. Murdock: "We authorize the services. Access authorizes the services when the clock starts for Medicare reimbursement, for that billing to take place. But again, it's going to change when Access actually starts seeing patients face-to-face. But I think that the biggest

issue, the biggest challenge, has been staffing. Four clinicians handle the daily 80 to 100 calls. And that's an average. Sometimes it's more than that. It's not always a client who's in need of services. Oftentimes it's family members. It's someone from out of the city, from out of county, from out of state, who just wants information for a relative who lives in San Francisco. In fact, I know that Access receives calls from individuals who have tried to locate individuals who are in San Francisco who they know have a mental health diagnosis with whom they have lost contact. So while a significant number of the calls are coming for services authorization into outpatient services, we also get a great number of calls that are information only. And oftentimes you can't answer the questions for confidentiality reasons."

Mr. Keys: "What is the level of experience needed by an employee to work for Access and take phone calls?"

Ms. Louie: "There are two Bachelor's level social workers on our staff and there are four Master's level positions, and two licensed level staff."

Mr. Murdock: "So the individuals who are answering the phones are either LCSWs, MFTs or Access level social workers."

As some of you may be aware and if any of you have been at 1380 Howard Street lately you noticed that there's some work happening on the first floor. We were very, very fortunate to find out that DPT, the Department of Parking and Traffic, decided to vacate the premises at 1380 on the first floor. It's a sizable space. It's almost the entire first floor. They moved to a new location at 11 South Van Ness. So if anybody needs to pay their tickets, you go to 11 South Van Ness, down at the corner of Van Ness and Market.

What CBHS decided to do was to go ahead and take over a master lease of the entire building at 1380 Howard Street and acquire that first floor for the purpose of combining and collocating various programs that are responsible for the outreach and placement of vulnerable populations into services. So the Mental Health Access team, which is currently on the second floor of 1380 Howard Street, is going to move down to the first floor. The pharmacy, which is on the second floor, is going to move down to the first floor. The Treatment Access Program (TAP), which is like Access's counterpart but on the substance abuse side, is going to move from its location at 679 Bryant Street over to the first floor of 1380 Howard. The COPE and OBIC programs — COPE is Comprehensive Office-Based Evaluation. There are two programs — an Office-Based Opiate Addiction Program and OBIC is the Buprenorphine Induction Clinic. These are narcotic replacement programs that work with opiate abusers.

All of these programs will be moving to the first floor of 1380 Howard Street. So there's a considerable amount of redesign that's going on downstairs. What's going to change, is that direct access to mental health and substance abuse services are actually, for the first time ever in the history of the Department of Public Health (DPH), going to be located in the same office. And their staffs are going to be more fully integrated so that we can address the needs of the myriad of individuals who are walking through the door, who have co-occurring disorders and who are dual diagnosed. That's the first thing.

The second thing is the Access staff will begin seeing patients face-to-face. People will be able to actually drop in and walk into 1380 Howard Street and meet immediately with a clinician from the Access staff or from the Treatment Access Program staff. That's a significant change from the way things have been done for the last few years. We're also going to have the pharmacy onsite that will be able to fill prescriptions for any of our

patients that are coming to any of these programs. After a client sees the clinician at Access or TAP, they can just walk down the hall to the pharmacy and get their prescription filled with absolutely no 11-hour wait."

Dr. Shukla: "Can Access clinicians write prescriptions?"

Mr. Murdock: "They can. But we are going to have a psychiatrist. The Medical Director of CBHS, Aaron Chapman is going to be providing some time downstairs to the programs so we will actually have the capability of a psychiatrist actually writing prescriptions. This is going to be a significant shift culturally and dynamically, in the way that 1380 Howard will now function. There were some concerns at 1380 Howard Street, mostly upstairs on the fourth and fifth floors. A lot contracts people, who are not clinicians had some concerns about what this was going to do with regards to issues of security, of foot traffic and presence in the building. We think that we've ameliorated those considerably. We had a building-wide meeting, so that all the staff could ask questions and be informed of what processes were taking place downstairs. And I think that a lot of those concerns have been rectified. We had two meetings with members of the community. Three people showed up, two at one meeting, one at the other. The two individuals at the first meeting came because they just wanted more information. At the second meeting, the third individual actually wanted us to provide more services. She thought that it would be a good idea that we located the safe injection site for injection drug users at 1380 Howard on the first floor. So there's a lot of really good stuff that's happening and I look forward to January when the facility opens. Of course we'll be inviting all stakeholders and interested parties to come to an opening that we're going to have. So in a nutshell, that's what's going to be happening at 1380 Howard."

Ms. Louie: "I just want to add that the seeing of clients will be phased in. It won't happen right away. TAP will see clients right away. They're seeing clients now."

Mr. Keys: "I get this sense that the phone portion of Access won't continue to grow or maybe even phase out?"

Mr. Murdock: "It may to a certain extent but we're obligated to keep it per a state regulation that requires that we keep the phone system going. But I think that it's appropriate clinical care if you can see the patient face-to-face. And we'd like to have the vast majority of the patients coming in who will be seen by a clinician face-to-face."

Mr. Keys: "The Mental Health Board would love to assist in any way, shape or form possible yet I believe that most of the times when we hear things like this we know that the persons presenting have some type of plan, and sometimes the assistance we could offer could be as simple as getting a grant writer to come in and do some aggressive grant writing so you can bring more money in and start doing some aggressive hiring or training of your staff. There are so many different avenues to take to shore up and strengthen a business, and I believe that, and I hope that I can speak for the rest of my colleagues in that we would certainly be more than happy to give whatever advice we can to you or perhaps even advocate in other places for you. But we have to see that you're going to be moving towards what we feel is a good space and a good place for people who are looking for your services."

Ms. Louie: "We welcome the help."

Mr. McGhee: "On behalf of the Mental Health Board, I want to thank Mr. Murdock and Ms. Louie for coming and making their presentation to us this evening."

Mr. Murdock: "Thank you."

2.2. Public Comment:

There was no Public comment.

ITEM 3.O Action Items:

3.1 Public comment relevant to Item 3.0

There was no public comment.

3.2 Proposed Resolutions

3.2.a PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of October 10, 2007 be approved as submitted.

Minutes approved unanimously.

3.2.b PROPOSED RESOLUTION: Be it resolved that the Mental Health Board commends Oprah Winfrey for two shows about Bipolar Disorder.

Resolution approved unanimously.

3.2.c. PROPOSED RESOLUTION: Be it resolved that the Mental Health Board urges DPH to create an RFP process for smaller non-profits.

Resolution approved unanimously.

3.2.d. PROPOSED RESOLUTION: Be it resolved that the Mental Health Board urges CBHS to develop more programs in the Southeast sector of the City.

Discussion:

Dr. Moses: "I like the resolution. I wish it were stronger. We constantly are asking CBHS to develop more programs in the southeast section of the City. I just think the resolution needs to be more compelling."

Ms. Brooke: "Ms. Brown can share the results of her discussions with Supervisor Maxwell."

Dr. Moses: "Can we copy this resolution to the Board of Supervisors?"

Ms. Brooke: "It goes there and it goes to the Health Commission as well as the Mayor. So as soon as it's approved here, it goes to all those places."

Mr. Keys: "I think this is wonderful. I was just in the southeast section the other day, and I was lost. I live downtown, so I don't know this area. I saw these kids playing and asked them how to get to where I was going, and they told me. There was nothing wrong, they weren't scared, they weren't some bad kids. They just reminded me of when I was that age. I would hope that if we're asking to bring in mental health services, that we're bringing in culturally competent mental health services into this area, not somebody that's just going to come in and say, 'You know what, you have a problem. You need to get on medication.' I think that we would hope that we could get people to go in who would say, 'I understand this is your lifestyle; this is the way you live. These are some of the things that you perhaps should look towards, like maybe you just need to work or get a little more education. Or maybe that's not it. You need to find some type of outlet.' I don't really see that in this resolution, but I hope that we could at some point press for that."

Mr. McGhee: "What I think Dr. Moses is saying is maybe we could change the language to coincide with the fact that Ms. Brown met with Supervisor Maxwell about holding a public hearing, and we could change this proposed resolution to say 'be it resolved that the Mental Health Board entertains a public hearing for CBHS to develop more programs in the southeast sector of the city.'"

Ms. Eichenbaum: "We could say something along the lines of, 'whereas the discrepancy in services in this area of the City is incredibly striking compared to other areas...' I mean, that's one thing that is missing from this. It is really well worded but there's no mention of the fact that it's an area of the City that has a lot of needs and it's all the more striking given the need, that the level of support is so low. Something around that kind of language could perhaps be inserted into this."

Ms. Kellum King: "It could also mention that in the southeast community the staffing is next to none. They have three medical professionals on staff. One is out on medical leave; the other one is working only part-time, and that leaves one person to service most of that community. That is unheard of and people should be jumping on tables and stomping their feet."

Mr. McGhee: "Let me make a recommendation. I think some of these topics should come up in the public hearing where we can get comments from the public itself. I don't have any problem if someone can come up with some language for this particular resolution. If we can then, if Dr. Moses doesn't mind, we could pass this resolution with the present language."

Ms. Brooke: "This one is just urging Community Behavioral Health Services to develop more programs in the southeast sector. You could work on another resolution that had stronger language and cover the more specific areas you want at next month's retreat."

Dr. Moses: "That would be good."

Mr. McGhee: "Then let's do that. Obviously we're not going to come up with the language this evening. Other people have other concerns that should be added to the resolution. So let's pass the resolution as is tonight, then work on a different one at the retreat."

Mr. Keys: "If we are going to pass this, we should vote on it. I just want to make sure that you're not pressuring us to vote on this right now."

Mr. McGhee: "I don't have a problem with passing this resolution as is with the fact that it goes right on the agenda for our retreat, where we can draw up a different one with stronger language that more directly addresses our concerns."

Resolution approved unanimously..

3.2.e PROPOSED RESOLUTION: Be it resolved that the Mental Health Board approves construction of the Behavioral Health Access Program at 1380 Howard Street.

Discussion:

Ms. Brooke: "This is just turning into a resolution the letter that you approved at the last meeting because the Board members asked that we make this a formal resolution. So it says exactly what the letter said."

Mr. Keys: "Will this disrupt services at 1380 Howard for any patients?"

Ms. Brooke: "No. The proposed changes to the first floor are quite exciting. There'll be pharmacy services; there'll be direct face-to-face contact with Access and clients. People will be able to actually sit down with someone rather than getting services over the phone. And it won't disrupt the rest of the building at all."

Ms. Brown: "The Department of Parking and Traffic is moving?"

Ms. Brooke: "They are already gone. They moved out four or five months ago."

Resolution approved unanimously.

Mr. McGhee: "What I would like to do at this time is recognize former Board member Benito Casados for a heroic deed he performed by coming to the aid of an elderly woman who was being assaulted on a MUNI bus.

The commendation reads: 'The Mental Health Board of San Francisco commends Benito Casados. On October 11, 2007, an elderly woman was accosted on the number 14 Mission Street MUNI bus and you courageously came to her aid. Her assailant stabbed you in the chest, near your heart, risking your life in this feat of heroism. For your courageous action we give you our deepest gratitude.'"

Mr. Casados: "I didn't do this for something like this. I did it because if it had been my mother I would have done the same thing or anybody else that I knew. Today, a lot of times I find that a lot of people have disrespect for older people. We should treat them with respect because that's what they deserve. And I believe that. When this happened, that was the reason I stepped in. I would not allow it to happen to my sister, my mother, my brother, anybody, and not do something about it. So I couldn't sit there and watch this lady get slapped and not step in and help her. Thank you."

ITEM 4.0 Reports:

4.1 Report from the Executive Director of the Mental Health Board.

Ms. Brooke: "Mr. Keys called me and mentioned that there is an upcoming Health Commission meeting, and wanted to see if we could have one of our Board members attend. Mr. Keys, do you have anything to say?"

Mr. Keys: "In my new position, I attend a lot of meetings, and I just attended one at the Health Commission. I feel there needs to be a Mental Health Board presence at the Commission to insure that mental health is seen as a great concern in the City. I was hoping that we could try to find some type of way to get one of our members on the Health Commission."

Ms. Brooke: "Roma Guy has been asking us to recommend people, including Board members who have a strong background in mental health."

Ms. Brown: "When do they meet?"

Ms. Brooke: "They are daytime meetings on Tuesdays. They start around 2:00 or 3:00 p.m. It's a Mayoral appointment, but if we had either someone on the Board who really was interested, or somebody in the community who has a strong, mental health background, we can write to Ms. Guy. She's very supportive of the work we do."

Mr. Keys: "It's a good meeting, with a packed audience. The Director of the Department of Public Health is there to answer questions."

Ms. Brooke: "It requires a lot of reading. They approve all the contracts. They meet every week too; so it's every single Tuesday and you have a lot of reading. You have to be on a committee as well.

Supervisor Duffy's office called today to say that they're having the second part of a hearing tomorrow on mental and behavioral health services in schools at 3:30 p.m. in the Board of Supervisors' chambers. If anybody is interested in that area, and if you do want to go, call me or call the supervisor's office directly and say you'll be there. Supervisor Duffy will recognize you.

I just want to proudly call your attention to the *USA Today* Opinion Letter that I wrote. It's in your packet. It's a brief letter I wrote in response to an article that *USA Today* did on post-traumatic stress disorder in male soldiers coming back. It's a good article, and it was well done, but my response was that there's a lot happening to the women over there too and that we need to look at what their needs are as well.

I want to call your attention to the MHB Snapshot. We're bringing this back. Some of you might not even remember it. This is something that Rich Snowdon innovated and it's a way to highlight things that the Board has done or Board members have done. James Keys has a brand new exciting job; Bridgett Brown met with Supervisor Maxwell; my *USA Today* article. Ms. Brown and I both spoke in Sacramento and then Kevin Hines, whom we mentioned earlier, is the speaker at an upcoming CBHS conference.

The next thing coming up on the veterans' issue is that on January 18th there's another free CBHS conference on veterans. That's a Friday; so if anyone's interested in going let me know. I also want to call your attention to the financial review that's in your packet from Susan Maher. We passed. Our books are in order, our 990's are filed, and our cost report is filed. We're in good shape. At the retreat I'll have a budget update.

Mr. Hines, who is the one who initiated and wrote the resolution for Oprah Winfrey, would like us to do it on a nicer plaque rather than just a plain piece of paper. Ms. Baltrip Balagas and I have been doing research on that. And I think for somewhere between a hundred and a hundred twenty dollars or so we could get a nice plaque. "

Ms. Brown: "How are we going to get it to her?"

Ms. Brooke: "Mr. Hines has her address. If you can believe it, he has turned Ms. Winfrey down three times because he was too busy to go on the show. I'm in support of a nice plaque because I think she'll take it more seriously. It'll be from the Mental Health Board. Who knows? She might invite us on the show."

Mr. Keys: "Then I want all of our names on it too."

Ms. Brooke: "We can do that. At the retreat we'll have the draft so that Board members can then approve it.

At the retreat, we're going to be bringing Board applications and a sample letter. There are about nine of you who need to be reappointed by the end of January. I'm also going to be looking to make appointments for you with your supervisors in January.

Finally, the retreat is at the Nikko Hotel, the same place that we've had it before. And we'll send you out a whole packet of information as to what room we're in and the parking information. Your Executive Committee members will probably be asking various members of you to do certain parts of the retreat as well."

Mr. Keys: "I spoke with Supervisor Sandoval's aide, and he told me they got the message from the Board, and they've been trying to contact the person they want to serve on the Board, and have not had very much luck in doing so, I, in my own unique fashion, requested that they expedite this issue because we were coming up to our retreat and that we wanted to bring in our new members to have them there so we could get ready for our next year. I'm not sure when, or even if Sandoval's office has done that. Perhaps you should report on that."

Ms. Brooke: "I call Supervisor Sandoval's office every week. I have been doing so since July. That's when I sent him Dennis Yun and several other candidates that I had at the time. I just keep calling and they keep saying, 'We're working on it.' I sent Mr. Yun's name not long after that over to Supervisor Elsbernd as well because he also has a consumer opening. I do have several new applications that I'm going to be sending off as well. We'll see how that goes. Supervisor Elsbernd has someone that he wants to appoint, although it turned out to be a family member; so he's thinking about someone else. He may or may not appoint someone in the foreseeable future. The progress is slow."

4.2 Report of the Chair of the Board and the Executive Committee:

Mr. McGhee: "Speaker of the House, Nancy Pelosi's office is having a meeting tomorrow of the Veterans Roundtable, and I don't know if any of you have been keeping up with this but there is a tremendous suicide rate in veterans. I want to say CNN did their own internal report in contacting the states and I guess a lot of states really gave them good information and it appears that there's around 120 veterans coming back from our present war in Iraq committing suicide a week. Every week.

120 veterans nationally committing suicide per week is close to 6,500 per year. So obviously I think this Veterans Roundtable that Nancy Pelosi has put together is probably going to be about where we go with our veterans in terms of mental health issues. I received a call from her office asking me to attend. This is a very hot issue, and we need to look at how we can honor and help our soldiers returning from this war get the healthcare they deserve."

Mr. Keys: "See if you can get her to talk about HR676, which is about the National Health Insurance Act. Basically what this would do is create universal healthcare for our nation."

Mr. McGhee: "Email me. It's her senior staff who are organizing the Roundtable, and I'm sure she won't be there."

4.3 Report by Members of the Board on Their Activities on Behalf of the Board.

Mr. Keys: "I have a new job. After almost three years of service to District 6 and the District 6 Supervisor's office, I was offered a position as Health Program Director for the Senior Action Network. I accepted the job. I've been on the job for 14 days. I am the point person and we're doing Medi-Cal D, we're doing Healthy San Francisco. It's really exciting work, and I'm very pleased that my new job does not affect my position here on the Board."

4.4 New Business

There was no new business.

4.5 Public Comment to Item 4.0

There was no public comment.

5.0 Public Comment

Mr. Douglas: "When we talk about Access, it seems to me that they're already over-extended and they're going to get more over-extended when they move downstairs. It's really a bad situation and may get worse."

Mr. Keys: "I wholeheartedly agree. This move seems as though it's going to reduce, if not get rid of the call portion of their program."

Ms. Brown: "They're trying to make a one-stop shop but they're not even dealing with the problems that they have just with phone and no service yet."

Mr. Douglas: "I mean, it takes a skilled clinician to handle a phone call, and they really can't get rid of the phone component because it's mandated by state law."

Mr. Keys: "How is that going to help a person? I mean, you're going to triage them there at 1380 on the first floor and then send them out to get services?"

Dr. Shukla: "But the majority of the services are really more related to substance abuse and pain and recovery because they have the Treatment Access Program, the pharmacy, the Opiate Addiction Program. So I'm not sure if it's going to become much more focused for your average person that walks in and has depression or has a bipolar disorder."

Mr. McGhee: "We could invite them back in six months for a progress report."

Adjournment

Meeting adjourned at 8:30 p.m.



Gavin Newsom
Mayor

SAN FRANCISCO MENTAL HEALTH BOARD

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MENTAL HEALTH BOARD November 14, 2007

RESOLUTION (MHB-2007-06): COMMENDING OPRAH WINFREY FOR HOSTING TWO TELEVISION SHOWS ABOUT BIPOLAR DISORDER.

WHEREAS, Oprah Winfrey is a well known and well-respected television host throughout America, and

WHEREAS, she has a strong reputation of presenting challenging issues that are of concern to many people, and

WHEREAS, Ms. Winfrey is very compassionate and very understanding of people with mental health issues or other problems, and

WHEREAS, Bipolar Disorder is a serious mental illness impacting 1.2% of the adult population with 25% attempting suicide, and

WHEREAS, onset is usually by age 30, sometimes later, and often slow to be diagnosed, causing fear and confusion in people struggling with this disorder, and

WHEREAS, 65% to 95% are stable between episodes, the rest chronically impaired, and

WHEREAS, Bipolar Disorder affects the entire family, not just the person with the disorder, and

BE IT RESOLVED, that the two shows hosted by Oprah Winfrey focused on Bipolar Disorder were greatly informative about this disorder, well thought out and very sensitive, and

BE IT FURTHER RESOLVED, that the two shows were very educational for people with little experience or understanding about the daily experience of a person with mental illness, and

BE IT FURTHER RESOLVED, that the shows put a real human touch to the disease and made it clear that this was a disease of the brain and not something you should just "snap out of", and

BE IT FURTHER RESOLVED, that the Oprah shows on Bipolar Disorder contributed greatly to an understanding of this disease by both those with the disease and others, and that it has led to people talking about the disease, and to internet blogs, leading to greater awareness of this disorder around the country, and

BE IT FURTHER RESOLVED, that the San Francisco Mental Health Board, and all people fighting for mental health awareness and education, thank you and appreciate you, Oprah Winfrey, from the bottom of our hearts for airing the two shows about Bipolar Disorder.

MENTAL HEALTH BOARD
November 14, 2007

RESOLUTION (MHB-2007-07): THAT THE MENTAL HEALTH BOARD URGES COMMUNITY BEHAVIORAL HEALTH SERVICES (CBHS) TO CREATE AN RFP PROCESS FOR SMALLER NON-PROFITS.

WHEREAS, larger non-profit organizations are applying for and being granted contracts with CBHS to provide services, and

WHEREAS, larger non-profit organizations have sufficient staffing to attend proposal meetings, and delegate appropriate staff to spend the time needed to complete the proposals, and

WHEREAS, larger non-profit organizations have developed the experience and expertise to respond effectively and successfully to the City's Request for Proposals, and

WHEREAS, the Mental Health Services Act sought innovative program designs and new ways of approaching mental illness, and

WHEREAS, follow up research by the Mental Health Association determined that front line staff was relatively unaware of anything new about the MHSA funded portion of their programs,

WHEREAS, smaller non-profit organizations might have new and innovative programs to offer, and

WHEREAS, smaller non-profit organizations often do not have enough staff to allocate the time necessary to respond to the City's RFP process, and

WHEREAS, the City's RFP process requires significant documentation, research, and proposal writing expertise, and

BE IT RESOLVED, that the Mental Health Board contends that many smaller non-profit organizations in San Francisco have developed innovative and creative programs that would significantly benefit people in the community if additional funding were available from the City, and

BE IT FURTHER RESOLVED, that the Mental Health Board requests of Community Behavioral Health Services that it develop technical assistance workshops, or provide staff capable of providing technical assistance for smaller non-profits to respond to requests for proposals, and

BE IT FURTHER RESOLVED, that Community Behavioral Health Services require larger non-profits to develop partnerships with smaller non-profits in order to be granted a contract for a proposal.

MENTAL HEALTH BOARD
November 14, 2007

RESOLUTION (MHB-2007-08): THAT THE MENTAL HEALTH BOARD URGES COMMUNITY BEHAVIORAL HEALTH SERVICES (CBHS) TO DEVELOP MORE PROGRAMS IN THE SOUTHEAST SECTOR OF SAN FRANCISCO.

WHEREAS, Community Behavioral Health Services has approximately 270 programs, a mix of civil service programs and contracts with non-profit organizations, and

WHEREAS, the Southeast sector of the City, comprising the Bayview Hunter's Point area and Visitation Valley, has evidenced serious issues with community violence and the mental health impact of that violence, and

WHEREAS, the Southeast sector of the City has a significant number of African American citizens which comprise nearly 25% of the people served by CBHS, even though African Americans number less than 10% of the City's population, and

WHEREAS, adults, families, children, and teens living in the Southeast sector have been actively seeking mental health services, and supportive living situations, and

WHEREAS, public meetings held to develop the plan for the Mental Health Services Act funding continually stressed the need for more programs in the Southeast sector, and

WHEREAS, of the 270 programs funded by CBHS, only 13, or 4%, are located in the Bayview Hunter's Point area and none are located in Visitation Valley, and

WHEREAS, of the 192 people served by the Full Service Partnership funding of the Mental Health Services Act, only 6 are known to be from the Bayview or Visitation Valley areas, and

BE IT RESOLVED, that the Mental Health Board urges Community Behavioral Health Services to actively outreach to the Visitation Valley and Bayview Hunter's Point areas of the City to determine what programs are needed in those areas, and

BE IT FURTHER RESOLVED, that the Mental Health Board urges Community Behavioral Health Services to outreach to the Visitation Valley and Bayview Hunter's Point areas to enroll additional people in the Full Service Partnerships, and

BE IT FURTHER RESOLVED, that Community Behavioral Health Services at the very least, to increase the funding to the few programs in the Bayview Hunter's Point area, so that these programs will be able to serve additional people.

MENTAL HEALTH BOARD
November 14, 2007

RESOLUTION (MHB-2007-09): THAT THE MENTAL HEALTH BOARD approves construction of the Behavioral Health Access Program at 1380 Howard Street.

WHEREAS, the Behavioral Health Access Program at 1380 Howard Street will include expansion of CBHS pharmacy and Mental Health Access program services, and the relocation of the Treatment Access Program (TAP), the Centralized Opiate Program Evaluation (COPE), and the Outpatient Buprenorphine Induction Clinic (OBIC) at 1380 Howard Street, and,

WHEREAS, by centralizing these important programs in a single location, CBHS will be able to provide a welcoming and responsive environment for clients with behavioral health issues and to streamline access to integrated services, and,

WHEREAS, in addition, the Center setting will allow Mental Health Access staff to provide face-to-face assessment services as convenient in addition to the current telephone consultation model. The location of this array of services at 1380 Howard is an important step in providing truly integrated behavioral health care in San Francisco.

BE IT RESOLVED, The Mental Health Board of San Francisco is pleased to provide this letter of support for the proposed "Behavioral Health Access Center."

Mental Health Board

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December 8, 2007

Mental Health Board Annual Retreat

Saturday, December 8, 2007

Nikko Hotel

222 Mason Street

Bayview Room, 25th Floor

AGENDA

- 1.0 Board Accomplishments
 - 1.1 Public Comment
- 2.0 Getting to Know You Icebreaker
 - 2.1 Public Comment
- 3.0 Goals Brainstorming for 2008
 - 3.1 Public Comment
- 4.0 Planning for 2008
 - 4.1 Public Comment
- 5.0 Planning the May Event
 - Re-appointment procedures
 - Ad Hoc Committee on Golden Gate Bridge Rail

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Ad Hoc Committee to look at contract and RFP process
Resolution Drafting: Services in the Southeast

Sector

Golden Gate Bridge

Barrier

Women and Girl's

Services

5.1 Public Comment

6.0 Adjourn

No final votes will be taken on any action items at the Retreat. All issues arising at the Retreat which require a vote of the Board will be placed on the agenda for the regular meeting of the Board on January 10, 2007. For further information, please call the office at 415-255-3474.

DISABILITY ACCESS

1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Edwin Batongbacal at (415) 255-3446 (voice) or (415) 255-3449 (TTD). Five days notice before the meeting will help to ensure the presence of an ASL interpreter or sound enhancement system. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.

2. The Retreat is held at the Nikko Hotel, 222 Mason Street, Bayview Room, 25th Floor, San Francisco . The closest accessible BART station is the Powel Street station, at the intersection of Powell and Market Streets. Also, the J, K, L, M, and N lines underground. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415)

351-7000.

3. Special Hearings are held at the Department of Public Health, 101 Grove Street, 3rd Floor, Room 300. The same public transportation options as above apply. It is wheelchair accessible.

3. The Nikko is accessible to wheelchairs. Elevators, doorways, restrooms, and the meeting room are wheelchair accessible.

4. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City accommodate these individuals.

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to the people's review. For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact:

Frank Darby
Sunshine Ordinance Task Force
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689
Telephone: (415)554-7724
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E-mail: sotf@sfgov.org

Citizens interested in obtaining a free copy of the Sunshine Ordinance can request one from Mr. Darby or by printing Chapter 67 of the San Francisco Administrative Code from the internet at: **www.sfgov.org/sunshine.htm**

To view Mental Health Board agendas and minutes, you may visit the MHB web page at: **www.sfgov.org/mental_health**. You may also go to the Government Information Center at the Main Library at Larkin and Grove in the Civic Center. You may also get copies of these documents through the MHB office at 255-3474.

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www.sfgov.org/ethics.





SAN FRANCISCO MENTAL HEALTH BOARD

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Mayor

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MENTAL HEALTH BOARD Retreat Notes

Saturday, December 8, 2007
Hotel Nikko
222 Mason Street
San Francisco
9 a.m. – 4 p. m.

BOARD MEMBERS PRESENT: James L. McGhee (Chair); Jagruti Shukla, M.D., M.P.H (Vice Chair); James Shaye Keys (Secretary); Bridgett Brown; Claudia Lebish; Tom Purvis; Richard Rodriguez, Ph.D; Lisa Williams; Virginia Wright.

BOARD MEMBERS ABSENT: Kevin Hines; LaVaughn Kellum King; Toye Moses, Ph.D., M.P.H.

OTHERS PRESENT: Helynna Brooke (MHB Executive Director); Ayana Baltrip-Balagas (MHB Administrator).

MEETING NOTES

CALL TO ORDER

The meeting was called to order at 9:10 a.m. by James L. McGhee (Chair)

ROLL CALL

AGENDA CHANGES

No changes were made.

WELCOME AND INTRODUCTIONS

ICEBREAKER

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1.0 Accomplishments of the Mental Health Board 2007

1.1 Mental Health Board News

Good morning, I would like to welcome our new board member, Dr. Richard Rodriguez who is filling a Mental Health Professional Seat. Dr. Rodriguez is an Alliant University colleague of our former chair, Dr. Rebecca Turner who recommended him to the Board.

1.2 Powerpoint presentation by James L. McGhee with discussion by the full Board:

I'd like to highlight the Board's accomplishments over the last year.

Slides Outline:

Presentations to the Board:

- Robin Love, MCP: Disproportionality Task Force, Foster Care
- Richard Heasley: New Directions in Supportive Housing
- Toni Heineman, PhD Counseling for Foster Care Children,
- Sherilyn Adams, Larkin Street Youth Services; Jackie Jenks, Central City Hospitality House; Gay Kaplan, Curry Senior Center: Supportive Services For Housing
- Bob Bennett, Ceo: Family Service Agency
- Public Hearing On The Annual Update To The Mental Health Services Act Plan
- Update On Board Activities And Discussion Of Future Goals Presentations to the Board:
- Steve Fields: Urgent Care Center
- Janice Avery, MFT and Calvin Thomas, Outreach Coordinator: Family Mosaic Project
- Craig Murdock, Program Director, Lila Louie, Clinical Director: ACCESS

Commendations by the Board

- Commendation for Carmen Lee and Stamp Out Stigma
- Commendation for Behavioral Health Court
- Commendation for Oprah Winfrey

Resolutions by the Board

- Responding to Critical Foster Care Issues and Concerns
- Budget Letter
- DPH to create an RFP process for smaller non-profits
- CBHS to develop more programs in the Southeast sector of the City
- Approves construction of the Behavioral Health Access Program at 1380 Howard Street.

Supervisors attending the Board Meetings

- Supervisor Jew in March: District 4 Issues

Supervisors board members met with in the past year

- Bevan Dufty: Jeanna Eichenbaum
- Aaron Peskin: James L. McGhee
- Chris Daly: James Keys
- Sophie Maxwell: Bridgett Brown

Program Reviews

- CVE: James McGhee
- Family Mosaic: Toye Moses, LaVaughn Kellum King
- Mental Health Association: Rebecca Turner
- Instituto Familiar de la Raza: Jeanna Eichenbaum
- Larkin Street: James Keys
- Walden House: Claudia Lebish

Individual Board Members Activities on Behalf of the Board

- James McGhee, James Keys, Benito Casados, Jeanne Eichenbaum, Jagruti Shukla, Kevin Hines, Lisa Williams, Virginia Wright, Toye Moses and Tom Purvis attended the Regional Mental Health Board training
- James McGhee was elected President of the Board of Psychology
- James McGhee attended the CALMHB meeting
- Bob Douglas, Bridgett Brown and LaVaughn Kellum King were panelists for Police Crisis Intervention Trainings
- Virginia Wright, LaVaughn Kellum King and Bridgett Brown served on the MHSA Task Force Advisory Committee.
- Tom Purvis attended the NAMI San Francisco and NAMI CA conferences.
- Bob Douglas was appointed to the CIMH Policy Council
- LaVaughn Kellum King read one of her poems to Jesse Jackson and received an award from the Presbyterian Church
- Kevin Hines was invited to join the National Speakers Bureau
- Kevin Hines was a presenter at the CBHS Conference about suicide.
- Kevin Hines was a presenter at the CBHS conference for consumers and families
- Kevin Hines was a speaker at the American Association of Suicidology, as well as speaking in Seattle, Philadelphia and around the country.

- LaVaughn Kellum King attended a conference on the criminal justice system and mental illness in Sacramento.
- Bridgett Brown was a panelist for the California Institute of Mental Health about Police Crisis Intervention Training.

Major Board Events

- Two showings of the movie, "The Bridge" with Rebecca Turner, PhD and Kevin Hines hosting one on May 16th and James McGhee and Kevin Hines hosting the second one on June 6th both in collaboration with CBHS and the Marin MHB.
- Gala Awards Reception for Exceptional People and Programs with 100 people attending including Assemblyman Mervyn Dymally, Dr. Jacqueline Horn, Belva Davis, Public Defender Jeff Adachi, Supervisor Maxwell, and numerous judges and Executive Directors of programs.

Which Board members are on MHB committees?

- May Event Planning Committee: Tom Purvis, James L. McGhee, James Keys, Bridgett Brown, Jagruti Shukla, MD, MPH, Virginia Wright, Lisa Williams, Benito Casados
- Executive Committee: Rebecca Turner, PhD, James L. McGhee, Lisa Williams, James Keys, Casados, (Tom Purvis – for Planning Committee), Bridgett Brown
- Nominating Committee (ad hoc) Toye Moses, PhD, Bridgett Brown, Lisa Williams

Innovations by the Board

- Expanding our website
- Beautiful Brochure

What progress has been made toward the 2006 goals we set at the last retreat?

- **Goal #1: Develop new partnerships with other organizations in order to collaborate on mental health issues.**

Goal #1 Achievements:

- Small Business Commission
- Behavioral Health Court
- The Coro Foundation
- *The Bridge* Screenings with CBHS and Marin Mental Health Board
- And, we maintained our long-term partnerships with SFPD and MHA

- **Goal #2: Lead and participate in education and advocacy efforts in identified legislative areas.**

Goal #2 Achievements

- Presentations about violence in the Bayview and Foster Care issues

- **Goal #3: Provide education to San Francisco organizations and the community about critical mental health issues.**

Goal #3 Achievements

- Our letter of concern to the Board of Supervisors on reduction of beds at SFGH
- Our Budget Letter
- Our letter in support of the continuation of Behavioral Health Court
- PCIT Training activities by Kate Walker, Benito Casados, Bob Douglas, Tom Purvis, Bridgett Brown, LaVaughn Kellum King

Activities Carrying Over to 2008

2.0 Icebreaker:

James Shaye Keys (Secretary); Lisa Williams; Virginia Wright

3.0 Goals and Brainstorming for 2008:

- Look at providing holistic services for individuals and illnesses
- Look at suicide: what communities are most affected
- Examine diversity issues: what are the psychological effects of sexism, racism, homophobia
- Look at cultural-based issues of access to mental health services for people of color, different genders: men versus women, and people of different sexual orientations
- Look at insecurity regarding our mental health and mental health access and treatment and insure that mental health services are respectful and dignified.
- Advocate for better legislation—HR 676 has a good mental health component.
- Advocate for Universal Health Care and single payer form of health care
- Look at veterans, including women and mental health access and treatment: especially homeless vets; improving the care
- Hold a citywide conference on mental health in 2009
- Look at improving the level of care in mental health rehabilitation facilities
- Define “recovery:” What are the next steps after recovery? What happens to those who cannot recover?
- Increase education about mental health including looking at the legal issues surrounding mental health care: conservators, guardians, LPS laws.
- Strengthen our voice for education and advocacy for African-American youth and youth in schools
- Look at funding sources to help families
- Look at safe havens for people of color and Lesbian Gay Bisexual Transgender (LGBT)

- Look at preventative care: mental health services need to be more like primary care services. They shouldn't kick in only in times of crisis.
- Need longer clinic hours; 24/7 crisis care
- Mental health services should be available when patients come in for medical issues: There is a need for more communication between medical and mental health services
- There needs to be stronger preventative measures, especially for Post-Traumatic Stress Disorder and violence
- Write a resolution to the Board of Supervisors and the Mayor for better access to medical and mental health care
- There is a lack of care for patients with dual diagnosis
- Need to look at the state of mental health emergency care in a disaster: What do we have in place?
- What is the state of mental health care for women and girls: How and why are different services needed? Discussion of menstrual cycle as a part of recovery.

3.1: What We've Done and What We Can Do:

- Support HR 676 and promote in the media
- Support SB 840: Universal Health Care
- Invite back presenters to follow up on their work
- Write Op/Ed pieces
- Work with Supervisor Sophie Maxwell
- Post relevant links to our website on articles and news and op eds
- Establish a Mental Health and Prevention Task Force
- Hold a Mental Health Hearing on how San Francisco could be providing better services
- Hold quarterly public hearings in different areas of the City to increase communication of mental health issues
- Continue to look at foster care issues
- Advocate for primary care and health
- Find out more about the RFP process for smaller non profits; look into providing technical support.
- Services in the Southeast Sector
- Mental Health Study – maybe a student could do the project – Committee to determine issues we want to research and have students analyze data
- Follow up media piece in community papers or BABW after speakers.
- Leadership Council
- Be more proactively involved in the budget process
- Re-define committees

4.0 2008 Goals:

Goal #1: Further investigate mental health services and advocate for increased funds in the Southeast sector by way of a needs assessment hearing, and present findings to relevant stakeholders and policymakers for the City and County of San Francisco.

- Conduct a needs assessment/utilization study
- Hold a public hearing
- Do outreach to community-based organizations (CBOs) and explore developing a public relations campaign for the media

- Educate CBOs in this area of the City about the Request for Proposal (RFP) process and how to get access to funding
- Present to Board of Supervisors

Goal #2: Investigate mental health issues for veterans, including women veterans, through research and communication to advocate and collaborate with current stakeholders.

- Conduct a needs assessment/utilization study
 - Look at both veterans from Iraq and Vietnam
- Develop partnerships with Speaker Pelosi, the Veterans Administration and other coalitions (25) and stakeholders
- Look at suicide and homeless rates as they pertain to veterans
- Research substance abuse as it pertains to veterans
- Develop a list of programs that are providing service to veterans
- Educate on mental health issues facing veterans

Goal #3: Investigate and research points of entry to mental health services throughout the City and County of San Francisco.

- Advocate for funding for 24/7 crisis centers
- Increase awareness of access issues experienced by clients
- Look into universal health care and other insurance issues
- Conduct a focused public hearing on the Access Program with the Mayor and Supervisors
- Follow up on the status of the Urgent Care Centers in six months with a Board meeting
- Work toward increasing access to mental health services through point-of-entry and availability of acute and preventative services

5.0 May 2008 Event:

- Refer to Planning Committee
- Tie in awards to MHB 2008 goals
- Get a celebrity name involved

ADJOURNMENT:

There being no further business, the meeting was adjourned at 4:00 p.m.





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THE MENTAL HEALTH BOARD
MEETING
FOR
WEDNESDAY, DECEMBER 12, 2007
IS CANCELED.

The next Mental Health Board meeting is scheduled for Wednesday, January 9, 2008

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